IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

SUSIE WILLIAMS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**Civil Action No.** 2:07-CV-321-WKW
	)	
VIVA HEALTH INC., and RICKY CRAPP,	)	**(Removed from the Circuit Court of Bullock County, CV-07-15)**
	)	
Defendants.	)	

NOTICE OF REMOVAL

Pursuant to 28 U.S.C. §§ 1441, *et seq.,* Defendants VIVA Health Inc. ("VIVA Health") hereby gives notice of the removal of this action from the Circuit Court of Bullock County, Alabama, where it is now pending, to the United States District Court for the Middle District of Alabama, Northern Division. As grounds for this removal, VIVA Health shows as follows:

I. PROCUDRAL MATTERS

1. This action was commenced against Defendants in the Circuit Court of Bullock County, Alabama, on March 13, 2007, when Plaintiff's Complaint was filed. True and correct copies of all the pleadings, process, and orders served upon Defendants in said action are attached hereto as Exhibit 1 and incorporated herein.

2. Less than thirty days have passed since VIVA Health was served with a copy of the Complaint. The initial pleading setting forth the Plaintiff's claims for relief was first received by any Defendant on March 14, 2007, when the Complaint was served on VIVA Health. Because this Notice of Removal is filed within thirty (30) days of receipt of the Plaintiff's Summons and Complaint, this removal is timely under 28 U.S.C. § 1446(b).

3. Mr. Crapp does not need to join in this Notice of Removal at this time, since he has not been served, as reflected on the first page of Exhibit 1 hereto.

4. Pursuant to 28 U.S.C. § 1446(d), a copy of this Notice of Removal is being filed with the Clerk of the Circuit Court of Bullock County, Alabama, and is being served on all adverse parties.

II. FACTUAL BACKGROUND

5. Plaintiff enrolled in VIVA Medicare Plus Select ("VIVA Medicare") and in the VIVA Health option of the Public Education Employees' Health Insurance Plan ("PEEHIP"). Affidavit of Latrina Hicks ("Hicks Aff.") ¶ 4 (Exhibit 2 hereto). For Medicare eligible retirees such as Plaintiff, PEEHIP is secondary for hospital and medical benefits provided under Medicare. *Id.* ¶ 5. For enrolled participants in VIVA Medicare, VIVA Health is the Medicare Advantage organization (with VIVA Medicare's being the Medicare Advantage plan) that

provides the Medicare coverage. *Id.* The PEEHIP prescription drug coverage is considered "creditable coverage" as defined by Medicare. *Id.*

6. As relevant to this removal,[1] Plaintiff's Complaint alleges three state law counts: (a) Count I, "Negligent Procurement," alleging that Defendants did not ensure Plaintiff had the best medical coverage for her diabetic condition, (b) Count III, alleging wanton failure to know what Plaintiff's "Medical status was and what coverage she had" and changing her "coverage to a plan that will leave her without vital medicine necessary for her survival," and (c) Count VI, alleging negligent hiring, training and supervision of Defendant Crapp in his job as a sales representative, "result[ing] in Plaintiff being enrolled in a health plan which was totally inadequate." The gist of these claims is that Defendants did not ask Plaintiff questions to determine her diabetic condition and then use those answers to persuade her not to enroll with VIVA Health.

7. In the Complaint, Plaintiff alleges that "Plaintiff received a solicitation via U.S. Mail to enroll in VIVA prescription drug program," Plaintiff contacted Defendants and enrolled in VIVA Health's prescription drug program, and later "Plaintiff discovered through her local pharmacists that [VIVA Health]

[1] In Plaintiff's Complaint, Counts II, IV and V allege that VIVA Health wrongfully failed, after being requested, to re-enroll Plaintiff in her original PEEHIP plan "administered by Blue Cross Blue Shield of Alabama." Plaintiff does not allege how VIVA Health might have been able to force Blue Cross to re-enroll Plaintiff.

would only cover $3,000.00 of her prescription drugs in any calendar year and would not pay for syringes." Complaint ¶¶ 7-13.

8. Plaintiff alleges that Plaintiff "and her local Pharmacist have made every effort to correct the problems created by defendant's negligence and outrageous conduct to no avail." Complaint ¶ 18. Plaintiff has not, however, submitted any claim of any type to VIVA Health for drugs, syringes, or anything else that has not been paid. Hicks Aff. ¶ 7. The applicable Evidence of Coverage has a Grievance Procedure and a Complaint Procedure. Hicks Aff., Ex. A, pp. 52-73. Plaintiff has not submitted any grievance or complaint to VIVA Health. Hicks Aff. ¶ 7. Therefore, Plaintiff has not exhausted the administrative remedies required by federal law.

9. A copy of the mailing that was sent to Plaintiff before she enrolled with VIVA Health is attached as Exhibit B to the Hick's Affidavit. The mailing explains as follows: "Prescription benefits are limited to $3,000 per member per calendar year." *Id.* This prescription benefit was reviewed by an actuary and approved as creditable coverage as defined by the Centers for Medicare & Medicaid Services ("CMS"). Hick's Aff. ¶ 8. Nonetheless, due to Plaintiff's diabetic condition, VIVA Medicare or PEEHIP, if Plaintiff had submitted a grievance or complaint, would have covered prescriptions related to Plaintiff's

diabetic condition, as part of the medical management of the diabetic condition. *Id.* ¶ 9.

10. Plaintiff has disenrolled from VIVA Medicare and enrolled in regular Medicare and still has PEEHIP coverage as secondary to Medicare. If Plaintiff had submitted a grievance or complaint for her drug or syringe claims related to her diabetic condition, under Plaintiff's alleged circumstances, those claims would have been paid. If Plaintiff submits drug or syringe claims related to her diabetic condition now, VIVA Health expects that such claims will be paid. Hicks Aff. ¶ 9-10.

III. FEDERAL QUESTION JURISDICTION

11. Federal question jurisdiction exists where a plaintiff's suit "arises under" the "Constitution, treaties or laws of the United States." 28 U.S.C. § 1331. In general, a case "arises under" federal law if the plaintiff pleads a cause of action created by federal law or if a substantial disputed area of federal law is a necessary element of a state law claim. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust,* 463 U.S. 1, 9-10, 13, 103 S. Ct. 2841 (1983).

12. Plaintiff's claims arise under federal law both because (a) based on federal preemption of the state law relied upon by Plaintiff, Plaintiff has pled a claim under federal law and (b) Plaintiff has pled a claim for which a substantial disputed area of federal law is a necessary or "embedded" element.

13. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") (Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C.)), expressly preempts state law with respect to any aspect for which there are federal standards for Medicare Advantage plans such as VIVA Medicare. Plaintiff alleges claims preempted by federal law because there are such federal standards that govern the subject matter of her claims.

14. The MMA's preemption of state law is broad. When interpreting an express preemption clause, a Court first focuses on the plain meaning of the statutory language, which provides the best evidence of congressional intent. *CSX Transp., Inc. v. Easterwood,* 507 U.S. 658, 664, 113 S. Ct. 1732 (1993). The relevant statutory language is found in 42 U.S.C. § 1395w-26(b)(3), which provides as follows:

> The standards established under this part shall supersede any state law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under this part.

See 42 C.F.R. § 422.402 (having essentially the same preemption language). The language of the MMA preemption clause is clear: If Medicare establishes standards with respect to Plaintiff's claims, then those standards supersede state law and Plaintiff's state law claims are preempted.

15. In discerning the scope of express preemption, the Court may look to the statutory framework and the structure and purposes of the statute as a whole.

Medtronic v. Lohr, 518 U.S. 470, 484, 116 S. Ct. 2240 (1996). The Medicare statutes and regulations create a complex national program that requires administration by agencies with expertise in the area. As CMS has noted when discussing the preemption provision with respect to the Medicare managed care program, "Congress intended that the . . . program, a Federal program, operate under Federal rules." 69 Fed. Reg. 46904 (Aug. 3, 2004). Furthermore, CMS has expressed its opinion that, with the MMA, Congress broadened the scope of preemption and has recognized that "establishing a uniform set of grievance standards [would] reduce confusion and burden for enrollees and plans." 70 Fed. Reg. 4362 (Jan. 28, 2005). Under the MMA, "state laws are *presumed to be preempted* unless they relate to licensure or solvency." 70 Fed. Reg. 4319 (emphasis added).

16. The gist of Plaintiff's claims is that Defendants should have kept Plaintiff from enrolling in VIVA Medicare due to her diabetic condition. Federal law prohibits this type of discrimination against beneficiaries by Medicare Advantage plans such as VIVA Medicare. 42 C.F.R. § 422.110; *see* Medicare Marketing Guidelines for Medicare Advantage Plans, p. 126 ("[P]lans are subject to sanction for engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (i.e.,

health screening or 'cherry picking')"); *id.*, p. 128 ("Providers contracted with plans (and their contractors) cannot . . . [h]ealth screen when distributing information to patients, as health screening is a prohibited marketing activity"). The federal standards further provide as follows:

> An individual performing marketing may be in a position to enroll healthier beneficiaries into specific health plans (or "cherry pick"). "Cherry picking" healthier patients is problematic because it distorts the market and can be viewed as discriminatory. Therefore an individual performing marketing must not "cherry pick".

Id., p. 129. In essence, Plaintiff's Complaint seeks to hold Defendants liable for not gathering information to health screen and for not cherry picking (by persuading Plaintiff not to enroll with VIVA Medicare) and to hold VIVA Health liable for not training Mr. Crapp to cherry pick. Therefore, whatever state laws Plaintiff might be relying upon are expressly preempted by federal law.

17. The federal regulations for "approval of marketing materials and enrollment forms" preempt Plaintiff's claims insofar as they relate to VIVA Medicare's marketing materials or enrollment forms. *See* 42 C.F.R. § 423.50 (2005) ("Approval of marketing materials and enrollment forms"). The regulations establish comprehensive standards for marketing materials and enrollment forms and provide for a mandatory CMS approval process before materials and forms can be used. *Id.* Accordingly, to the extent that Plaintiff's claims depend on the

adequacy of VIVA Medicare's marketing materials or enrollment forms, Plaintiff's claims are preempted.

18. The Medicare Act incorporates section 405(h) of the Social Security Act. 42 U.S.C. § 1395ii. Section 405(h) of the Social Security Act, as incorporated into the Medicare Act, expressly provides that **no** "decision of the [Secretary of the Department of Health and Human Services] shall be reviewed by any person, tribunal, or governmental agency except as herein provided." 42 U.S.C. § 405(h). Congress, in developing the elaborate remedial scheme for review of Medicare decisions, clearly intended that it would supersede other mechanisms for challenging those decisions. *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 487- 88 (7th Cir. 1990). A plaintiff cannot avoid the Medicare Act's exclusive mechanism for challenging coverage decisions "simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits." *Id.* at 487. "If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." *Id.*

19. Here, Plaintiff seeks judicial review of her claims before she has exhausted the Medicare required administrative remedies for coverage

determinations and other grievances. In her Complaint, Plaintiff is asserting that VIVA Health would have denied claims as a Medicare Advantage organization for drugs or syringes, or that her current Medicare and PEEHIP will deny claims for drugs or syringes. Plaintiff's claims depend on coverage determinations that have not been submitted to the VIVA Medicare grievance or complaint process or to the regular Medicare grievance or complaint process, both of which could end with a determination by the Secretary. As result, Plaintiff's claims are preempted by § 405 and the federal standards set under that provision.

20. Under *Heckler v. Ringer*, 466 U.S. 602, 614-15, 104 S. Ct. 2013 (1984), any claim arising under the Medicare Act must be brought pursuant to § 405(g). Under § 405(h), § 405(g) is the sole avenue for judicial review of all claims arising under the Medicare Act. *Id.* If a claim is "inextricably intertwined" with a claim for Medicare benefits, the claim thereby arises under the Medicare Act, a federal law, and thus is completely preempted. *Id.* As explained above, Plaintiff has attempted to allege state law claims that are inextricably intertwined with a claim for Medicare benefits and thus are actually federal claims.

21. In addition to preemption, a state law claim for which a substantial disputed area of federal law is a necessary element also gives rise to federal question jurisdiction. In 2005, the Supreme Court held that a claim need not be brought under federal law for there to be valid federal question jurisdiction.

Grable & Sons Metal Prods. Inc. v. Darue Eng'g & Mfg., 545 U.S. 308, 317-18, 125 S. Ct. 2363 (2005); *see McCready v. White,* 417 F.3d 700, 702-03 (7th Cir. 2005) (noting that *Grable* put the "kibosh" on the possibility that a federal cause of action was necessary to establish federal question jurisdiction).

22. Under *Grable*, the dispositive question for federal question jurisdiction based on an embedded federal issue is as follows: "does a state-law claim necessarily raise a stated federal issue, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities." 545 U.S. at 314. The Supreme Court guided lower courts to engage in a "contextual inquiry" that examines "the importance of having a federal forum for the issue, and the consistency of such a forum with Congress's intended division of labor between state and federal courts." *Id.* at 318-19.

23. Plaintiff's claims present three embedded federal issues, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities: (a) Can Defendants be liable for compensatory and punitive damages to Plaintiff for not health screening her and then not persuading her to avoid VIVA Medicare coverage, when such health screening is prohibited by federal law? (b) Are VIVA Medicare's marketing materials and enrollment forms, which are to comply with

federal requirements, insufficient to disclose to Plaintiff the VIVA Medicare benefits? And, (c) Can Plaintiff avoid the federally mandated administrative remedies for Medicare Advantage plans, which is the Medicare Act's exclusive mechanism for challenging coverage decisions, by alleging a claim for collateral damages instead of a challenge to an expected denial of benefits?

24. Each of these three embedded federal issues a substantial and disputed federal issue and are an element of a claim pled by Plaintiff. A federal forum is important for one or all of the issues. Furthermore, Congress's intent of having a federal forum is indicated by the express preemption of state laws for these issues, as explained above.

25. Because Plaintiff has pled a claim under federal law or Plaintiff has pled a claim for which a substantial disputed area of federal law is a necessary element, this action may be removed under 28 U.S.C. § 1331.

26. Accordingly, this case is removable to this Court pursuant to 28 U.S.C. § 1441.

27. This Court has supplemental jurisdiction of any claims that this Court might find not to be preempted by federal law, because such claims, if any, are so related to Plaintiff's federal claim that they form part of the same case or controversy.

WHEREFORE, Defendant VIVA Health prays that this Court will make any and all orders necessary to effect the removal of this cause from the Circuit Court of Bullock County, Alabama, and to effect and prepare in this Court the true record of all proceedings that may have been had in this proceeding.

DATED this 12th day of April, 2007.

James S. Christie, Jr. (CHR011)

Amelia T. Driscoll (DRI016)
Bradley Arant Rose & White LLP
1819 Fifth Avenue North
Birmingham, AL 35203-2104
Telephone: (205) 521-8000
Facsimile: (205) 521-8800

Attorneys for Defendant
VIVA Health, Inc.

CERTIFICATE OF SERVICE

I hereby certify that I have this date served the above and foregoing on:

L. Cooper Rutland, Jr.
Rutland Law Firm, L.L.C.
208 North Prairie Street
Post Office Box 551
Union Springs, Alabama 36089
334-738-4770
lcrj@ustconline.net

by placing a copy of same in the United States Mail, first-class postage prepaid and addressed to his regular mailing address, on this 12th day of April, 2007.

James B. Christie, Jr.
One of the Attorneys for
Defendant VIVA Health, Inc.

EXHIBIT

1

AVSO351 CV 2007 000015.00

JUDGE: HON. BURT SMITHART

ALABAMA JUDICIAL DATA CENTER
CASE ACTION SUMMARY
CIRCUIT CIVIL

IN THE CIRCUIT COURT OF BULLOCK COUNTY

SUSIE WILLIAMS VS VIVA HEALTH INC. ET AL.
FILED: 03/13/2007 TYPE: NEGLIGENCE-GENERAL TYPE TRIAL: JURY TRACK:

DATE1: CA: CA DATE:
DATE2: AMT: $.00 PAYMENT:
DATE3:

PLAINTIFF 001: SUSIE WILLIAMS
C/O L. COOPER RUTLAND
P.O. BOX 550
UNION SPRINGS, AL 36089-0000
PHONE: (334)000-0000
ATTORNEY: RUTLAND L COOPER JR
RUT010
P. O. BOX 551
UNION SPRINGS, AL 360
(334)738-4770
ENTERED: 03/13/2007 ISSUED: TYPE:
SERVED: ANSWERED: JUDGEMENT:

DEFENDANT 001: VIVA HEALTH INC.
BRAD ROLLOW
1224 14TH AVENUE SOUTH
BIRMINGHAM, AL 35205-0000
PHONE: (334)000-0000
ATTORNEY:
ENTERED: 03/13/2007 ISSUED: 03/13/2007 TYPE: CERTIFIED
SERVED: 3/15/07 ANSWERED: JUDGEMENT:

DEFENDANT 002: CRAPP RICKY
1400 21ST STREET SOUTH
BIRMINGHAM, AL 35205-0000
PHONE: (334)000-0000
ATTORNEY:
ENTERED: 03/13/2007 ISSUED: 03/13/2007 TYPE: CERTIFIED
SERVED: ANSWERED: JUDGEMENT:

3/13/07	Summons + Complaint filed - forwarded by C.M.
3/15/07	Def #1 served by C.M.
3/20/07	Returned on D002. Unable to forward.

RAF 03/13/2007 CV 2007 000015.00

AVSO352

CASE: CV 2007 000015.00
JUDGE: HON. BURT SMITHART

ALABAMA JUDICIAL DATA CENTER
CASE ACTION SUMMARY CONTINUATION
CIRCUIT CIVIL

IN THE CIRCUIT COURT OF BULLOCK COUNTY

SUSIE WILLIAMS VS VIVA HEALTH INC. ET AL.
FILED: 03/13/2007 TYPE: NEGLIGENCE-GENERAL TYPE TRIAL: JURY TRACK:

DATE1: CA: CA DATE:
DATE2: AMT: $.00 PAYMENT:

RAF 03/13/2007

AVSO353 ALABAMA JUDICIAL DATA CENTER

FEE SHEET

CIRCUIT CIVIL CASE:CV 2007 000015.00

IN THE CIRCUIT COURT OF BULLOCK COUNTY JUDGE: HON. BURT SMITHART

SUSIE WILLIAMS VS VIVA HEALTH INC. ET AL.

PATTY:RUTLAND L COOPER JR DATTY:

P. O. BOX 551

UNION SPRINGS , AL 36089

CIVIL FEE SUMMARY	DATE AMT	DATE AMT	DATE AMT	DATE AMT
DOCKET FILING FEE				
SM(<) $62.00				
SM(>) $136.00				
DIST $227.00				
CIRC $226.00				
JU/CS $119.00				
LAW LIBRARY TAX	2.00			
JURY DEMAND				
SERVICE FEES				
EACH DEF OVER				
CERT MAIL				
SUBPOENA EACH				
ABND VEH $37.00				
WORKERS COMP $174.00				

CONTINUATION	DATE AMT	DATE AMT	DATE AMT	DATE AMT
OTHER SERVICES				
COMMISSION ON SALE				
JUDGEMENTS				
POST JUDGEMENT FEE				
ATTACHMENTS				
GARNISHMENTS				
EXECUTION				
APPEAL COSTS				
LOWER COURT COSTS				
OTHER				
COURT ADM FUND				
FAMILY COURT				
SHERIFF'S FEE				
TOTAL COSTS				

CASH RECEIPTS/FROM	DATE RECEIVED	RECEIPT NUMBER	AMOUNT RECEIVED	GARNISHEE

DISBURSEMENTS PAID TO	DATE PAID	CHECK NO	AMOUNT PAID

RAF 03/13/2007

State of Alabama
Unified Judicial System

Form ARCiv-93 Rev.5/99

COVER SHEET
CIRCUIT COURT – CIVIL CASE
(Not For Domestic Relations Cases)

Case Number: CV 2007 [ ][ ][ ][ ][ ] - [ ][ ]
Date of Filing: 03 (Month) 13 (Day) 2007 (Year)
Judge Code: [ ][ ][ ][ ][ ][ ]

GENERAL INFORMATION

IN THE CIRCUIT COURT OF BULLOCK COUNTY, ALABAMA
(Name of County)

Susie Williams (Plaintiff) v. VIVA Health Inc. (Defendant)

First Plaintiff: ☐ Business ☐ Individual ☐ Government ☐ Other
First Defendant: ☐ Business ☐ Individual ☐ Government ☐ Other

NATURE OF SUIT: Select primary cause of action, by checking box (check only one) that best characterizes your action:

TORTS: PERSONAL INJURY
- ☐ WDEA - Wrongful Death
- ☒ TONG - Negligence: General
- ☐ TOMV - Negligence: Motor Vehicle
- ☒ TOWA - Wantonness
- ☐ TOPL - Product Liability/AEMLD
- ☐ TOMM - Malpractice-Medical
- ☐ TOLM - Malpractice-Legal
- ☐ TOOM - Malpractice-Other
- ☐ TBFM - Fraud/Bad Faith/Misrepresentation
- ☒ TOXX - Other: Outrage

TORTS: PERSONAL INJURY
- ☐ TOPE - Personal Property
- ☐ TORE - Real Property

OTHER CIVIL FILINGS
- ☐ ABAN - Abandoned Automobile
- ☐ ACCT - Account & Nonmortgage
- ☐ APAA - Administrative Agency Appeal
- ☐ ADPA - Administrative Procedure Act
- ☐ ANPS - Adults in Need of Protective Services

OTHER CIVIL FILINGS (cont'd)
- ☐ MSXX - Birth/Death Certificate Modification/Bond Forfeiture Appeal/ Enforcement of Agency Subpoena/Petition to Preserve
- ☐ CVRT - Civil Rights
- ☐ COND - Condemnation/Eminent Domain/Right-of-Way
- ☐ CTMP - Contempt of Court
- ☒ CONT - Contract/Ejectment/Writ of Seizure
- ☐ TOCN - Conversion
- ☐ EQND - Equity Non-Damages Actions/Declaratory Judgment/Injunction Election Contest/Quiet Title/Sale For Division
- ☐ CVUD - Eviction Appeal/Unlawful Detainer
- ☐ FORJ - Foreign Judgment
- ☐ FORF - Fruits of Crime Forfeiture
- ☐ MSHC - Habeas Corpus/Extraordinary Writ/Mandamus/Prohibition
- ☐ PFAB - Protection From Abuse
- ☐ FELA - Railroad/Seaman (FELA)
- ☐ RPRO - Real Property
- ☐ WTEG - Will/Trust/Estate/Guardianship/Conservatorship
- ☐ COMP - Workers' Compensation
- ☐ CVXX - Miscellaneous Circuit Civil Case

ORIGIN (check one): F ☒ INITIAL FILING; A ☐ APPEAL FROM DISTRICT COURT; O ☐ OTHER: _____; R ☐ REMANDED; T ☐ TRANSFERRED FROM OTHER CIRCUIT COURT

HAS JURY TRIAL BEEN DEMANDED? ☒ YES ☐ NO
Note: Checking "Yes" does not constitute a demand for a jury trial. (See Rules 38 and 39, Ala.R.Civ.P, for procedure)

RELIEF REQUESTED: ☒ MONETARY AWARD REQUESTED ☐ NO MONETARY AWARD REQUESTED

ATTORNEY CODE: R U T 0 1 0

3-13-2007
Date

Signature of Attorney/Party filing this form

MEDIATION REQUESTED: ☐ YES ☒ NO ☐ UNDECIDED

ALABAMA JUDICIAL DATA CENTER
COURT PAYMENT SYSTEM

BULLOCK COUNTY RECEIPT NUMBER: [illegible]
DATE OF RECEIPT: 03/13/2007 TIME: 14:17:42
RECEIPT FOR CASE: CV 2007 [illegible] BATCH: 2007021
RECEIVED FROM: RUTLAND L COOPER JR

SUSIE WILLIAMS VS VIVA HEALTH INC. ET AL.

ACCOUNTS RECEIPTED:

CV05	$326.00
JDMS	$100.00

RECEIVED BY: RAF CHECK AMOUNT $426.00

CV-07-15

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Viva Health, Inc
Brad Rollow
1224 14th Ave South
Birmingham, AL 35205

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 5/10

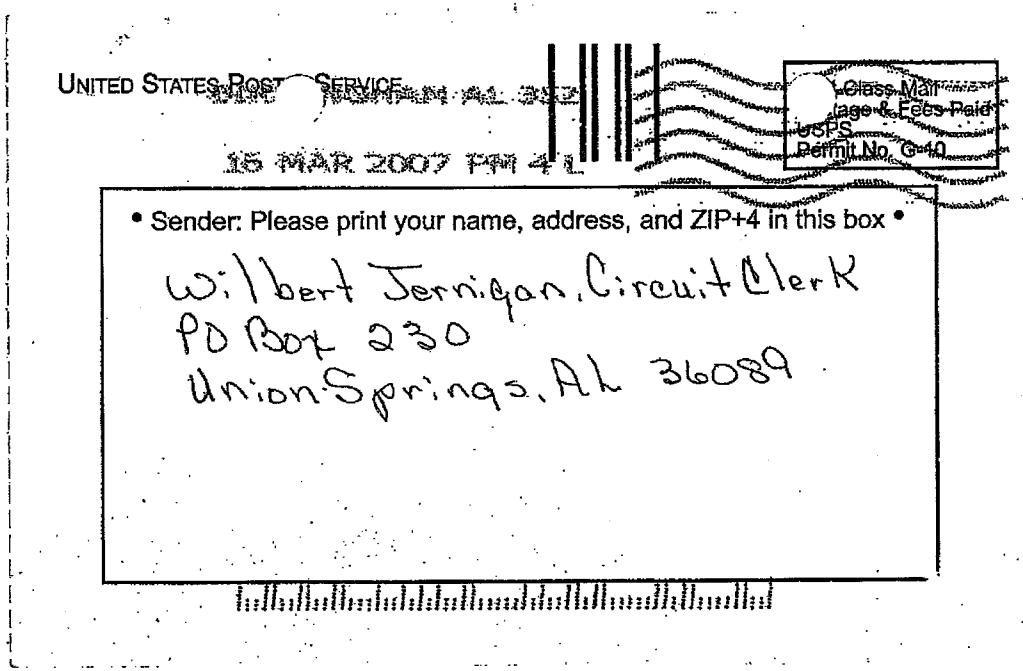
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7004 2890 0000 1193 3971

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540


UNITED STATES POST SERVICE
15 MAR 2007 PM 4 L
Class Mail
Postage & Fees Paid
USPS
Permit No. G-10
• Sender: Please print your name, address, and ZIP+4 in this box •
Wilbert Jernigan, Circuit Clerk
PO Box 230
Union Springs, AL 36089

7004 2890 0000 1193 9848

Wilbert Jernigan
Clerk & Register
Bullock County
Post Office Box 230
Union Springs, Alabama 36089

CERTIFIED MAIL

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE

★ ★ ★ UNITED STATES POSTAGE
105 PB8744806
5032 $08.58⁰ MAR 13 07
7343 UNION SPRINGS, AL 36089

Restricted Delivery

RETRUN RECEIPT REQUESTED

Mr. Ricky Crapp
1400 21st Street South
Birmingham, Alabama 35205

NIXIE 352 1 21 03/15/07
RETURN TO SENDER
ATTEMPTED - NOT KNOWN
UNABLE TO FORWARD
BC: 36089023030 *2075-00768-15-31

Zapata

3520543825-00 5004
36089x0230

CV-07-15

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Rocky Crapp
1400 21st Street South
Birmingham, AL 35205

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☒ Yes

2. Article Number (Transfer from service label) 7004 2890 0000 1193 3988

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

IN THE CIRCUIT COURT OF BULLOCK COUNTY, ALABAMA

SUSIE WILLLIAMS,

Plaintiff,

vs.

VIVA HEALTH, INC., et al.

Defendants.

CASE NO. CV-2007-15

CIVIL SUMMONS

NOTICE TO: **VIVA Health Inc.**
Brad Rollow
1224 14th Ave. South
Birmingham, Alabama 35205

The Complaint which is attached to this Summons is important and you must take immediate action to protect your rights. You or your attorney are required to mail or hand deliver a copy of a written Answer, either admitting or denying each allegation in the Complaint to the Plaintiff's Attorney:

L. Cooper Rutland, Jr.
Rutland Law, L.L.C.
Post Office Box 551
Union Springs, Alabama 36089
(334) 738-4770

The Answer must be mailed or delivered within 30 days after this Summons and Complaint were delivered to you or a Judgment by Default may be entered against you for the money or other things demanded in this Complaint. You must also file the original of your Answer with the Clerk of this Court.

THE SERVICE BY CERTIFIED MAIL OF THIS SUMMONS IS INITIATED UPON THE WRITTEN REQUEST OF L. COOPER RUTLAND, JR., PURSUANT TO RULE 4.1(c) OF THE ALABAMA RULES OF CIVIL PROCEDURE.

3-13-07
Date

Wilbert M. Jernigan by RMF
Wilbert M. Jernigan

SERVICE BY CERTIFIED MAIL IS HEREBY REQUESTED.

3-13-07
Date

L. Cooper Rutland, Jr.

CASE NO. CV-2007-15

RETURN OF SERVICE:

CERTIFIED MAIL RETURN RECEIPT RECEIVED IN THIS OFFICE ON (DATE)_____. (Return receipt hereto attached).

IN THE CIRCUIT COURT OF BULLOCK COUNTY, ALABAMA

SUSIE WILLIAMS

Plaintiff,

VS

VIVA HEALTH, INC., RICKY CRAPP and fictictous defendants A-Z, those individuals, partnerships, L.L.C.'s, Corporations, or other entities who are unknown to Plaintiff whose conduct contributed to the claims made herein who will be substituted by amendment when ascertained.

Defendant.

CV-07-15

FILED IN OFFICE

MAR 13 2007

CLERK-REGISTER, BULLOCK CO., ALA.

COMPLAINT
PARTIES

1. Plaintiff, Susie Williams, is an adult resident citizen of Bullock County, Alabama whose address is 14333 County Road 45, Union Springs, Alabama 36089.

2. Defendant, Viva Health, Inc., (VIVA) is an Alabama Corporation doing business in Bullock County, Alabama whose principle offices are located at 1400 21st Street South, Birmingham, Alabama 35205. Defendants agent for service of process is Brad Rollow, 1222 14th Ave. South, Birmingham, Alabama 35205.

3. Defendant, Ricky Crapp, is an adult resident citizen of Alabama, employed by Defendant, VIVA as a sales representative whose address for service for process is 1400 21st Street South, Birmingham, Alabama 35205.

4. Fictictous Defendants A-Z are those individuals, partnerships, L.L.C.'s, corporations or other entities who are unknown to the Plaintiff whose conduct contributed to the claims made herein

who will be substituted by amendment when ascertained.

5. Plaintiff makes some claims in the alternative is provided by the *Alabama Rules of Civil Procedure*.

6. Plaintiff brings all claims under applicable Alabama statutes and makes no claims which would in any way invoke federal jurisdiction.

FACTS

7. On or before October of 2006 Plaintiff received a solicitation via U.S. mail to enroll in VIVA prescription drug program.

8. Plaintiff had heard on numerous occasions about the governments new prescription drug program so she contacted the Defendant at the number provided on the mailer.

9. Defendant, Crapp, advised Plaintiff that VIVA's program was far superior to the prescription drug program Plaintiff was already enrolled in.

10. Defendants were already aware that Plaintiff was a member of the Public Education Employees Health Insurance Plan, (PEEHIP) and received benefits for prescription drugs through Blue Cross Blue Shield of Alabama and Express Scripts Inc.

11. In reliance on Defendant's statement that she would be better served by VIVA, Plaintiff filled out the enrollment application and forwarded it to defendants.

12. The Defendant's dis-enrolled Plaintiff from her PEEHIP program administered by Blue Cross Blue Shield of Alabama and re-enrolled her in VIVA's program.

13. Shortly thereafter Plaintiff discovered through her local Pharmacists that Defendant would only cover $3,000.00 of her prescription drugs in any calender year and would not pay for syringes.

14. This is significant to Plaintiff as she is diabetic and her prescription bills are in excess

of $8,000.00 annually.

15. Having discovered that her new insurance is totally inadequate, Plaintiff filed a dis-enrollment form with Defendants on December 12th, 2006.

16. Defendants ignored Plaintiff's request to be dis-enrolled or failed to take the necessary steps to insure Plaintiff was placed back in her original PEEHIP plan administered by Blue Cross Blue Shield of Alabama.

17. As a result of the Defendant's conduct Plaintiff's prescription drug coverage will run out in April of 2007 and she will be left without means to secure the insulin she needs to live.

18. This has caused Plaintiff great mental anguish and emotional stress. She and her local Pharmacist have made every effort to correct the problems created by defendant's negligence and outrageous conduct to no avail.

19. Plaintiff seeks damages to compensate her for expenses she otherwise would not have incurred and for mental anguish and emotional distress she has sufferred and continues to suffer.

20. Plaintiff Seeks punitive damages for the wanton, outrageous, intentional and willful conduct of Defendants in order to punish Defendants for their conduct and to deter them from committing such acts in the future.

Wherefore, Plaintiff demands judgement against all Defendants in such amounts as compensatory and punitive damages as a jury deems reasonable plus cost.

COUNT I
NEGLIGENT PROCUREMENT

21. Plaintiff re-alleges all paragraphs of the complaint as if as if filly set forth herein.

22. Defendants owed a duty to Plaintiff to ensure that she was provided the best insurance given her present medical conditions.

23. Defendants failed to procure adequate insurance for the Plaintiff.

24. Defendant's conduct was negligent in that the Plaintiff was left without coverage necessary to treat her diabetic condition.

25. As a proximate result Plaintiff was injured and damaged as aforsaid.

Wherefore, Plaintiff demands judgement of Defendants in such amounts of compensatory, damages as a jury deems reasonable plus cost.

COUNT II
NEGLIGENCE

26. Plaintiff re-alleges all paragraphs of the complaint as if fully set forth herein.

27. Defendants owed a duty to Plaintiff to ensure she was enrolled in her original PEEHIP plan after she advised them of her dis-enrollment.

28. Defendants were negligent in failing to enroll Plaintiff in her original PEEHIP plan.

29. As a proximate result, Plaintiff was injured and damaged as aforesaid.

Wherefore, Plaintiff demands judgement of Defendants in such amounts of compensatory, damages as a jury deems reasonable plus cost.

COUNT III
WANTONNESS

30. Plaintiff re-alleges all paragraph of the complaint as if fully set forth herein.

31. Defendants knew, or should have known prior to contacting Plaintiff what her medical status was and what insurance coverage she had.

32. Defendants changed Plaintiff's coverage to a plan that will leave her without vital medicine necessary for her survival.

33. Defendant's conduct was intentional, reckless, willful and wanton.

34. As a proximate result, Plaintiff was damaged as previously aforesaid.

Wherefore, Plaintiff demands judgement of Defendants in such amounts of compensatory, and punitive damages as a jury deems reasonable plus cost.

COUNT IV
OUTRAGE

35. Plaintiff re-alleges all paragraphs of the complaint as if fully set forth herein.

36. Defendants were repeatedly advised by Plaintiff and her Pharmacists that she should be dis-enrolled from VIVA's prescription drug program and placed back in her PEEHIP plan administered by Blue Cross Blue Shield of Alabama.

37. Defendants have ignored Plaintiff's requests and failed to re-enroll Plaintiff in her original health care plan.

38. Defendant's conduct was willful, intentional, reckless and outrageous to the point that it shocks the conscious of a reasonable prudent person.

39. As a proximate result the Plaintiff was injured and damaged as aforesaid.

Wherefore, Plaintiff demands judgement of Defendants in such amounts of compensatory, and punitive damages as a jury deems reasonable plus cost.

COUNT V
BREACH OF CONTRACT

40. Plaintiff re-alleges all paragraphs of the complaint as if fully set forth herein.

41. Defendants entered into a contract with plaintiff to provide health care coverage. Plaintiff had a contractual right to dis-enroll and did so.

42. Defendants failed to re-enroll Plaintiff in her original PEEHIP plan and has retained her in their program in breach of the agreement.

43. As a proximate result of Defendants breach, Plaintiff was injured and damaged as aforesaid.

Wherefore, Plaintiff demands judgement of Defendants in such amounts of compensatory, damages as a jury deems reasonable plus cost.

COUNT VI
NEGLIGENT HIRING, TRAINING, AND SUPERVISION

44. Plaintiff re-alleges all paragraphs of the complain as if fully set forth herein.

45. Defendant VIVA negligently hired, trained, and supervised Defendant, Crapp, in his job as a sales representative for the Defendant.

46. Defendants negligence resulted in Plaintiff being enrolled in a health care plan which was totally inadequate.

47. As a proximate result of Defendant's negligence, Plaintiff was injured and damaged as aforesaid.

Wherefore, Plaintiff demands judgement of Defendants in such amounts of compensatory, damages as a jury deems reasonable plus cost.

L. Cooper Rutland, Jr (RUT 010)
Attorney for Plaintiff

OF COUNSEL:
Rutland Law Firm, L.L.C.
208 North Prairie Street
Post Office Box 551
Union Springs, Alabama 36089
334-738-4770
lcrj@ustconline.net

JURY DEMAND

Plaintiff demands trial by Jury on all counts of the complaint.

Plaintiff

EXHIBIT

2

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

SUSIE WILLIAMS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**Civil Action No. _____**
	)	
VIVA HEALTH INC., and RICKY CRAPP,	)	**(Removed from the Circuit Court of Bullock County, CV-07-15)**
	)	
Defendants.	)	

AFFIDAVIT OF LATRINA HICKS

STATE OF ALABAMA)
:
JEFFERSON COUNTY)

Personally appeared before me, a Notary Public in and for said County and State, Latrina Hicks, who being known to me, and first duly sworn, deposes and says as follows:

1. My name is Latrina Hicks. The matters stated herein are within my personal knowledge or are contained in records kept by VIVA Health Inc. ("VIVA Health"). I am over the age of 19 and am otherwise competent to testify to the matters stated herein.

2. I am the Manager of Medicare Member Services for VIVA Health, one of the Defendants in the above-styled action. As part of my responsibilities for

VIVA Health, I am familiar with VIVA Health's procedures for processing and administering claims for medical coverage. I am personally familiar with the manner in which VIVA Health maintains files and records, including those that relate to Susie Williams ("Ms. Williams"). I am authorized to execute this affidavit as a representative of VIVA Health.

3. The documents attached hereto are kept by VIVA Health in the regular course of business relative to claims for benefits, and such records are made at the time of the acts, transactions, occurrences and/or events reflected in the records, or within a reasonable time thereafter, by someone with personal knowledge of such acts, transactions, conditions, opinions, occurrences and/or events.

4. Attached hereto as Exhibit A is a true and correct copy of the 2006 Evidence of Coverage for the VIVA Medicare Plus Select ("VIVA Medicare") . Ms. Williams enrolled in VIVA Medicare and in the VIVA Health option of the Public Education Employees' Health Insurance Plan ("PEEHIP") effective on October 1, 2006.

5. For Medicare eligible retirees such as Plaintiff, PEEHIP is secondary for hospital and medical benefits provided under Medicare. For participants enrolled in VIVA Medicare, VIVA Health is the Medicare Advantage organization (with VIVA Medicare's being the Medicare Advantage plan) that provides the

Medicare coverage. The PEEHIP prescription drug coverage is considered "creditable coverage" as defined by Medicare.

6. The Evidence of Coverage outlines the grievance and complaint procedure that participants in VIVA Medicare are to follow in the event of any complaint about an unpaid claim or any other type of issue. *See* Ex. A at 52-73.

7. Ms. Williams has never submitted a claim, grievance, or complaint of any type to VIVA Health.

8. Attached hereto as Exhibit B is a true and correct copy of a mailing that was sent to PEEHIP retirees eligible for Medicare, such as Ms. Williams, before she enrolled with VIVA Health. Before this mailing was sent to anyone, including Ms. Williams, the prescription benefit described therein was reviewed by an actuary and approved as creditable coverage as defined by the Centers for Medicare & Medicaid Services.

9. Even though the mailing that is Exhibit B makes clear that "[p]rescription benefits are limited to $3,000 per member per calendar year[,]" under the circumstances alleged by Ms. Williams, VIVA Health would have covered drug and syringe claims related to Ms. Williams's diabetic condition as part of the medical management of that condition had Ms. Williams submitted a covered drug or syringe grievance or complaint to VIVA Health. Likewise, if Ms. Williams submits drug or syringe claims related to her diabetic condition now,

under the circumstances alleged by Ms. Williams, VIVA Health expects that such claims will be paid.

10. Effective November 30, 2006, Ms. Williams disenrolled from VIVA Medicare and was, unless she enrolled in another Medicare Advantage plan, returned to regular Medicare. Ms. Williams still has PEEHIP coverage as secondary to Medicare.

I have read the foregoing Affidavit, ¶¶ 1-10, and I swear and affirm that it is true and correct to the best of my knowledge and belief.

Latrina Hicks

Latrina Hicks

Sworn to and subscribed before me
this the 12th day of April, 2007.

Notary Public for State of Alabama

My Commission Expires:

NOTARY PUBLIC STATE OF ALABAMA AT LARGE
MY COMMISSION EXPIRES: Aug 26, 2008
BONDED THRU NOTARY PUBLIC UNDERWRITERS

EXHIBIT

A

H0154

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of VIVA MEDICARE *Plus* SELECT

January 1 – December 31, 2006

This booklet gives the details about your VIVA MEDICARE *Plus* SELECT health coverage and explains how to get the care you need.
This booklet is an important legal document.
Please keep it in a safe place.

VIVA MEDICARE *Plus* Member Services:

For help or information, please call Member Services Monday through Friday, 8 a.m. to 5 p.m. at one of the numbers listed below:

205-918-2067 *in Birmingham or*
1-800-633-1542 *toll free*

TTY: Alabama Relay Service 1-800-548-2546

H0154

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of VIVA MEDICARE *PLUS* SELECT

January 1 – December 31, 2006

This booklet gives the details about your VIVA MEDICARE PLUS SELECT health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

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205-918-2067 in Birmingham or

1-800-633-1542 toll free

TTY: Alabama Relay Service 1-800-548-2546

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Welcome to *VIVA MEDICARE PLUS SELECT*!

We are pleased that you've chosen VIVA MEDICARE *PLUS* SELECT (referred to herein as "Plan").

VIVA MEDICARE PLUS SELECT is a health plan for people with Medicare

Now that you are enrolled in VIVA MEDICARE *PLUS* SELECT, you are getting your care through VIVA HEALTH, INC (referred to herein as "VIVA HEALTH"). VIVA MEDICARE *PLUS* SELECT is a health plan offered by VIVA HEALTH. **(VIVA MEDICARE PLUS SELECT is *not* a "Medigap" or supplemental Medicare insurance policy.)**

This booklet explains how to get your Medicare services through VIVA MEDICARE *PLUS* SELECT

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of VIVA MEDICARE PLUS SELECT. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2006, through December 31, 2006.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of VIVA MEDICARE PLUS SELECT. This booklet gives you the details, including:

- What is covered in VIVA MEDICARE *PLUS* SELECT and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay when you get care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave VIVA MEDICARE PLUS SELECT, including your choices for continuing Medicare if you leave.

This booklet may be available in alternative formats. Contact Member Services at the number on the cover of this booklet for more information.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with VIVA MEDICARE PLUS SELECT. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Table of Contents

Section 1 Telephone numbers and other information for reference

How to contact VIVA MEDICARE *PLUS* Member Services

If you have any questions or concerns, please call or write to VIVA MEDICARE *PLUS* Member Services. We will be happy to help you. Our business hours are Monday through Friday, 8 a.m. to 5 p.m.

CALL	205-918-2067 in Birmingham or 1-800-633-1542 toll free. These numbers are also on the cover of this booklet for easy reference.
TTY	The Alabama Relay Service at 1-800-548-2546. Calls to this number are free. This number requires special telephone equipment. It is on the cover of this booklet for easy reference.
FAX	1-205-939-1748.
WRITE	1400 21st Place South, Birmingham, Alabama 35205
WEBSITE	www.vivahealth.com

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline, 24 hours a day, 7 days a week

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Health Plans (including VIVA MEDICARE PLUS SELECT) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week, to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Calls to these numbers are free.
- Use a computer to look at **www.medicare.gov**, the official **government website for Medicare information.** This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plan and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

Alabama Department of Senior Services – an organization in your state that provides free Medicare help and information

The Alabama Department of Senior Services is a state organization paid by the federal government to give free health insurance information and help to people with Medicare. The Alabama Department of Senior Services can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. The Alabama Department of Senior Services has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage Plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan (like VIVA MEDICARE PLUS SELECT) for the first time. (Medicare Advantage is the new name for Medicare + Choice). Section 11 has more information about your Medigap guaranteed issue rights.

You can contact the Alabama Department of Senior Services at:

770 Washington Avenue
RSA Plaza, Suite 470
Montgomery, Alabama 36130
1-877-425-2243 (calls to this number are free)

You can also find the website for the Alabama Department of Senior Services at www.medicare.gov on the web.

Alabama Quality Assurance Foundation/Quality Improvement Organization – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Alabama, the QIO is called the Alabama Quality Assurance Foundation. The doctors and other health experts in the Alabama Quality Assurance Foundation review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 9 for more information about complaints.

You can contact the Alabama Quality Assurance Foundation at:

Two Perimeter Park South, Suite 200 West
Birmingham, Alabama 35243-2337
1-205-977-4205 or
1-800-760-3540 (calls to this number are free)

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact VIVA MEDICARE *PLUS* Member Services at 1-800-633-1542 (calls to this number are free). TTY users should call the Alabama Relay Service at 1-800-548-2546 (calls to this number are free). Our business hours are Monday through Friday, 8 a.m. to 5 p.m. You may also contact:

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104
1-334-242-5000 or
1-800-362-1504 (calls to this number are free)

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. Calls to these numbers are free. You can also visit **www.ssa.gov** on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY users should call 1-312-751-4701. You can also visit **www.rrb.gov** on the web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

Section 2 Getting the care you need, including some rules you must follow

What is VIVA MEDICARE PLUS SELECT?

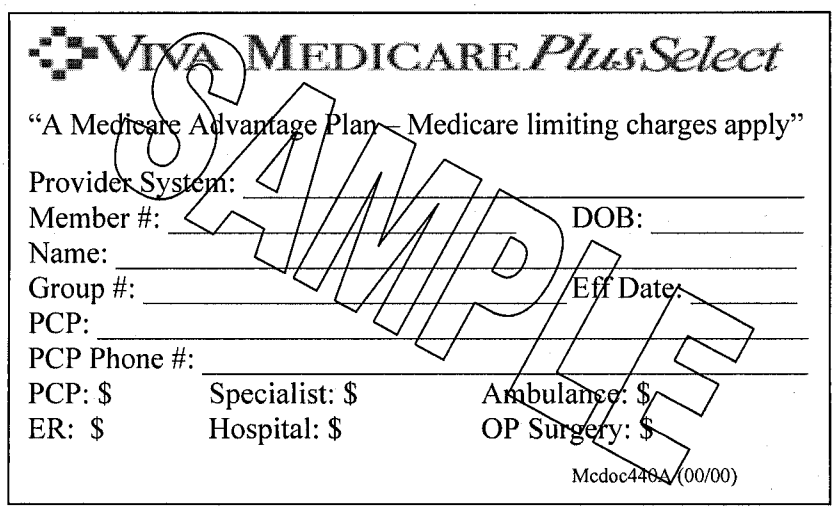
Now that you are enrolled in VIVA MEDICARE PLUS SELECT, you are getting your Medicare through VIVA MEDICARE PLUS SELECT. VIVA MEDICARE PLUS SELECT is offered by VIVA HEALTH, and is a health plan for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of VIVA MEDICARE PLUS SELECT. (VIVA MEDICARE PLUS SELECT is **not** a Medicare supplement policy. See Section 13 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) VIVA MEDICARE PLUS SELECT provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. VIVA MEDICARE PLUS SELECT gives you all of the usual Medicare services that are covered for everyone with Medicare. We also give you some additional services and supplies, such as yearly routine physical exams and one routine eye exam every 12 months. Since VIVA MEDICARE PLUS SELECT is a Medicare health plan, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of VIVA MEDICARE PLUS SELECT provider system. Since these doctors, hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).

Use your Plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of VIVA MEDICARE PLUS SELECT, you have a VIVA MEDICARE PLUS SELECT membership card. Here is a sample card to show what it looks like:

FRONT OF CARD



mcdoc452r1A (1/06)

BACK OF CARD

This plan has a prior authorization requirement for certain services. In a medical emergency, dial 911 or go to the nearest hospital and notify VIVA Health within 24 hours. No PCP referral needed to see specialist in provider system.

Members: (205) 918-2067 or (800) 633-1542
TTY: (800) 548-2546
Providers: (205) 558-7473 or (800) 294-7780
Precerts: (205) 933-1201 or (800) 294-7780

Send claims to VIVA Medicare Plus:
P.O. Box 55209
Birmingham, AL 35255-5209

During the time you are a Plan member and using Plan services, **you *must* use your VIVA MEDICARE PLUS SELECT membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. **If you get covered services using your red, white, and blue Medicare card instead of your VIVA MEDICARE PLUS SELECT membership card while you are a Plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.**

Please carry your VIVA MEDICARE PLUS SELECT membership card with you at all times. You will need to show this card when you get covered services. If your ID card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your membership record up to date

VIVA MEDICARE PLUS SELECT has a file of information about you as a Plan member. Doctors, hospitals and other Plan providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific VIVA MEDICARE PLUS SELECT coverage, the Personal Care Physician, and provider system you chose when you enrolled, and other information. Section 8 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Services know right away if there are any changes in your name, address, or telephone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. Call the number on the cover of this booklet to contact Member Services.

What is the geographic service area for VIVA MEDICARE PLUS SELECT?

The counties in our service area are Autauga, Blount, Bullock, Chilton, Crenshaw, Elmore, Jefferson, Lowndes, Macon, Montgomery, Pike, Shelby and St. Clair Counties.

Using Plan providers in your selected provider system to get services covered by VIVA MEDICARE PLUS SELECT

You will be using Plan providers in your selected provider system to get covered services

Now that you are a member of VIVA MEDICARE PLUS SELECT, with few exceptions, **you must use Plan providers to get your covered services.**

- **What are "Plan providers"?** "Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "Plan providers" when they participate in VIVA MEDICARE PLUS SELECT. When we say that Plan providers "participate in VIVA MEDICARE PLUS SELECT," this means that we have arranged with them to coordinate or provide covered services to members of VIVA MEDICARE PLUS SELECT.
- **What is a "provider system"?** "Provider system" is the general term we use to describe the group of Plan PCP's, specialists, hospital(s), and other health care providers whom you have selected to get all your covered services from. When you select a PCP, you are also choosing your provider system. While VIVA MEDICARE PLUS SELECT may contract with specialists and hospitals in other provider systems, you will receive most or all of your care from Plan specialists and hospital(s) in your selected provider system.
- **What are "covered services"?** "Covered services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by VIVA MEDICARE PLUS SELECT. Covered services are listed in the Benefits Chart in Section 4.

As we explain below, you will have to choose one of our Plan providers to be your PCP, which stands for Personal Care Physician. Your PCP is available to provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say "non-plan providers," we mean providers that are **not** part of VIVA MEDICARE PLUS SELECT.)

The Provider Directory gives you a list of Plan providers

Every year as long as you are a member of VIVA MEDICARE PLUS SELECT, we will send you a Provider Directory, which gives you a list of Plan providers in your selected provider system. If you don't have the Provider Directory, you can get a copy from Member Services (call the number on the cover of this booklet). You may also get a complete list of our Plan providers on our website at www.vivahealth.com. You can ask Member Services for more information about Plan providers, including their qualifications and experience. Member Services can give you the most up to date information about changes in Plan providers and about which ones are accepting new patients.

Access to care and information from Plan providers

You have the right to get timely access to Plan providers and to all services covered by the Plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 8 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Personal Care Physician)

What is a "PCP"?

When you become a member of VIVA MEDICARE PLUS SELECT, you must choose a Plan provider to be your PCP. Your PCP is a physician who meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you get as a Plan member.

How do you choose a PCP?

You selected a PCP and hospital at the time you filled out a form to enroll in VIVA MEDICARE PLUS SELECT. The name and office telephone number of your PCP is printed on your membership card, as well as the name of your provider system. You may change your PCP at any time (as explained later in this section). If there is a particular VIVA MEDICARE PLUS SELECT specialist or hospital that you want to use, check first to be sure your PCP is in the same provider system as the specialist and hospital that you want to use.

Getting care from your PCP

You can see your PCP for most of your routine health care needs. Besides providing much of your care, your PCP can help arrange or coordinate the rest of the covered services you get as a Plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other Plan providers about your care and how it is going. In some cases, your PCP will need to get prior authorization (prior approval) for your covered services. Since your PCP can provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 8 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by telephone or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is *not* a medical emergency, call your PCP's telephone number (shown on your membership card). For TTY services, call the Alabama Relay Service toll free at 1-800-548-2546 and have them place the call for you. There should always be a health professional on call to help you.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions).

You do not need a referral from your PCP before you see a Plan specialist in your selected provider system. However, if there are specific specialists you want to use, find out whether your specialists are in the same provider system as your PCP. **The VIVA MEDICARE PLUS SELECT specialists you can use depends on which person you chose to be your PCP. You can use only the specialists in your selected provider system.**

You can change your PCP at any time. Later in this section, under "How to Change your PCP," we tell you how to change your PCP. If there is a specific hospital you want to use, find out whether your PCP uses this hospital. The provider directory for your selected provider system gives you a list of Plan providers you can use.

Getting care when you travel or are away from the Plan's service area

If you need care when you are outside the service area, your coverage is very limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that VIVA MEDICARE PLUS SELECT or a Plan provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number on the cover of this booklet.

How to change your PCP

You may change your PCP for any reason. In most cases, we will make the change effective the day you call (unless you are currently in a hospital that is part of your selected provider system and the PCP will change your selected provider system). To change your PCP, call Member Services at the number on the cover of this booklet. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services (such as home health agency services and durable medical equipment) if the PCP change will change your selected provider system. Member Services will tell you if you can continue with the specialty care and other services you have been getting when you change to a new PCP. If you change to a new

PCP in a different provider system, the hospital(s), specialists and other Plan providers you can use will change. Member Services will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and telephone number of your new PCP.

What if your doctor leaves VIVA MEDICARE PLUS SELECT?

Sometimes a PCP, specialist, clinic, or other Plan provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of VIVA MEDICARE PLUS SELECT. If your PCP leaves VIVA MEDICARE PLUS SELECT, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger** – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP (Personal Care Physician) or other Plan provider.** (Section 2 tells about your PCP and Plan providers.)
- Make sure that your PCP and VIVA HEALTH know about your emergency, because we will need to be involved in following up on your emergency care. You or someone else should call to tell your PCP and VIVA HEALTH about your emergency care as soon as possible, preferably within 48 hours. Your PCP's and VIVA HEALTH's telephone numbers are on your VIVA MEDICARE PLUS SELECT membership card.

Your PCP will help manage and follow up on your emergency care

Your PCP or VIVA HEALTH will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, your PCP and VIVA HEALTH will try to arrange for Plan providers in your selected provider system to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for

the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **only if you get it from a Plan provider in your selected provider system.**
- If you get any additional care from a non-plan provider or a provider that is not in your selected provider system after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is "urgently needed care"? (This is different from a medical emergency)

"Urgently needed care" is **when you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to get medical care from your PCP or other Plan providers in your selected provider system. In these cases, your health is *not* in serious danger. As we explain below, how you get "urgently needed care" depends on whether you need it when you are in the Plan's service area, or outside the Plan's service area. Section 2 tells about the Plan's service area.

What is the difference between a "medical emergency" and "urgently needed care"?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. "Urgently needed care" is if you need medical help immediately, but your health is not in serious danger. A "medical emergency" is if you believe that your health is in serious danger.

Getting urgently needed care when you are in the Plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the Plan's service area, please call your PCP's telephone number (shown on your VIVA MEDICARE PLUS SELECT membership card). There will always be a health professional on call to help you. For TTY services, call the Alabama Relay Service at 1-800-548-2546 and have them place the call for you. Keep in mind that if you have an urgent need for care while you are in the Plan's service area, we expect you to get this care from Plan providers in your selected provider system. In most cases, we will not pay for urgently needed care that you get from a non-plan provider while you are in the Plan's service area.

Getting urgently needed care when you are outside the Plan's service area

VIVA MEDICARE PLUS SELECT covers urgently needed care that you get from non-plan providers when you are outside the Plan's service area. If you need urgent care while you are outside the Plan's service area, we prefer that you call your PCP or VIVA HEALTH first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP or a Plan provider in your selected provider system. However, we will cover follow-up care that you get from non-plan providers outside the Plan's service area as long as the care you are getting still meets the definition of "urgently needed care."

We cover renal (kidney) dialysis services that you get when you are temporarily outside the Plan's service area (for up to six months in a row).

Section 4 Benefits Chart – a list of the covered services you get as a member of VIVA MEDICARE PLUS SELECT

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of VIVA MEDICARE PLUS SELECT. **"Covered services" means the medical care, services, supplies, and equipment that are covered by VIVA MEDICARE PLUS SELECT.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called "exclusions"). Section 5 also tells about **limitations** on certain services.

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. (See Section 13 for a definition of "medically necessary.") Certain preventive care and screening tests are also covered.
- With few exceptions, covered services must either be provided by Plan providers in your selected provider system or be authorized by VIVA HEALTH. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the Plan's service area.

In addition, some covered services require "prior authorization" in order to be covered

Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other Plan provider in your selected provider system gets "prior authorization" (approval in advance) from VIVA HEALTH's Medical Management Department. Covered services that need prior authorization are marked in the Benefits Chart in italics under the section heading.

Benefits Chart – a list of covered services

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient Services	
Inpatient hospital care For more information about hospital care, see Section 6. *Requires prior authorization (approval in advance) to be covered, except in a medical emergency.* You are covered for unlimited days. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 6 for more information about transplants. • Blood - Coverage begins with the first pint of blood that you need. • Physician Services.	You pay: • $100 for each Medicare-covered stay at a Plan hospital. • $100 for each inpatient stay at a non-plan hospital for Plan approved post stabilization care following an emergency condition. • 20% coinsurance up to a maximum out-of-pocket cost to you of $3,000 per transplant procedure.
Inpatient mental health care Includes mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The benefit days used under the Original Medicare program will count toward the 190-day lifetime limit. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. *Requires prior authorization (approval in advance) to be covered, except in a medical emergency.*	You pay $100 for each Medicare-covered stay at a Plan hospital.

Benefits chart – your covered services	What you must pay when you get these covered services
Skilled nursing facility care For more information about skilled nursing facility care, see Section 6. *Requires prior authorization (approval in advance) to be covered.* You are covered for 100 days each benefit period. See Section 13 for the definition of a benefit period. No prior hospital stay is required. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	You pay: • $0 each day for days 1-14. • $75 each day for days 15-28. • $0 each day for days 29-100. There is a $1,050 maximum out of pocket limit every calendar year.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient services (when the hospital or SNF days are not or are no longer covered) For more information, see Section 6. *Requires prior authorization (approval in advance) to be covered.*	You pay:
• Physician services.	• $5 for each Personal Care Physician (PCP) visit.
• Diagnostic tests (like X-ray or lab tests).	
• X-ray, radium, and isotope therapy including technician materials and services.	• $10 for each specialist visit.
• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.	
• Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.	• 20% of the cost for each Medicare-covered item.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.	• 20% of the cost for each Medicare-covered item.
• Physical therapy, speech therapy, and occupational therapy.	• $25 for each Medicare-covered physical, occupational, and/or speech/language therapy visit.
Home health care For more information about home health care, see Section 6. *Requires prior authorization (approval in advance) to be covered.*	There is no copayment for Medicare-covered home health visits.
Home Health Agency Care:	
• Part-time or intermittent skilled nursing and home health aide services.	
• Physical therapy, occupational therapy, and speech therapy.	
• Medical social services.	
• Medical equipment and supplies.	

Benefits chart – your covered services	What you must pay when you get these covered services
Hospice care For more information about hospice services, see Section 6. • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.	When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see Section 6 for more information about hospice services).
Outpatient Services	
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center in your selected provider system. • Consultation, diagnosis, and treatment by a specialist in your selected provider system. • Second opinion by another Plan provider in your selected provider system prior to surgery. • Outpatient hospital services. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor). • Routine physical exam including routine lab tests. You are covered for one (1) exam every year from your PCP.	You pay: • $5 for each Personal Care Physician (PCP) visit for Medicare-covered services. • $10 for each specialist visit for Medicare-covered services. • $5 for each routine physical exam from your PCP.
Chiropractic services • Manual manipulation of the spine to correct subluxation.	You pay $10 for each Medicare-covered visit.

Benefits chart – your covered services	What you must pay when you get these covered services
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	You pay $10 for each Medicare-covered visit (medically necessary foot care).
Outpatient mental health care (including Partial Hospitalization Services) *Requires prior authorization (approval in advance) to be covered.* Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	For Medicare-covered mental health services, you pay $20 for each individual/group therapy visit.
Outpatient substance abuse services *Requires prior authorization (approval in advance) to be covered.*	For Medicare-covered services, you pay $20 for each individual/group visit.
Outpatient surgery *Requires prior authorization (approval in advance) to be covered.* Also includes invasive diagnostic procedures such as diagnostic colonoscopies, epidurals, and EGDs.	You pay $100 for each Medicare-covered visit to an ambulatory surgical center or an outpatient hospital facility up to a maximum out-of-pocket cost to you of $1,000 per calendar year.
Ambulance services *Requires prior authorization (approval in advance) to be covered, except in a medical emergency.* Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	You pay $100 per one-way trip for Medicare-covered ambulance services.

Benefits chart – your covered services	What you must pay when you get these covered services
Emergency care For more information, see Section 3. Worldwide coverage.	You pay: • $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. • $100 for each Medicare-covered emergency admission into a hospital. • $100 for each inpatient stay at a non-plan hospital for Plan approved post stabilization care following an emergency condition.

Benefits chart – your covered services	What you must pay when you get these covered services
Urgently needed care For more information, see Section 3. Worldwide coverage.	For each Medicare-covered urgently needed care visit you pay: • $5 at a PCP's office. • $10 at a specialist's office. • $20 at an urgent care facility/clinic. • $50 at a hospital emergency room; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.
Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) *Requires prior authorization (approval in advance) to be covered.*	You pay: • $25 for each Medicare-covered physical, occupational, and/or speech/language therapy visit.
Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	• $0 for Medicare-covered cardiac rehabilitation.

Benefits chart – your covered services	What you must pay when you get these covered services
Durable medical equipment and related supplies – such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 13). *Requires prior authorization (approval in advance) to be covered.*	You pay 20% of the cost for each Medicare-covered item.
Prosthetic devices and related supplies – (other than dental) which replace a body part or function. *Requires prior authorization (approval in advance) to be covered.*	You pay:
• Includes pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail.	• 20% of the cost for each Medicare-covered item.
• Ostomy supplies including colostomy bags and supplies directly related to colostomy care.	• $0 for ostomy supplies.

Benefits chart – your covered services	What you must pay when you get these covered services
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). *Requires prior authorization (approval in advance) to be covered. VIVA HEALTH may limit coverage of diabetic supplies to a particular name or brand. The type or brand may vary by Plan Provider.*	You pay:
• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.	• $5 per standard-size box for each Medicare-covered diabetes supply item.
• One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.	• $0 for Medicare-covered therapeutic shoes, fitting and inserts.
• Self-management training is covered under certain conditions.	• $0 for Medicare-covered self-management training and fasting plasma glucose tests. Doctor office visit copayment may apply.
• For persons at risk of diabetes: Fasting plasma glucose tests. Contact Member Services for information on how often we will cover these tests.	
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor. *Requires prior authorization (approval in advance) to be covered.*	There is no copayment for medical nutrition therapy. Doctor office visit copayment may apply.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies *Some services require prior authorization (approval in advance) to be covered.*	
• X-rays. • Outpatient radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests.	• There is no copayment for Medicare-covered x-rays, radiation therapy, supplies and lab tests.
• Blood - Coverage begins with the first pint of blood that you need, including storage and administration.	• There is no copayment for blood.
Preventive Care and Screening Tests	
Bone mass measurements	
For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no copayment for each Medicare-covered bone mass measurement. Doctor office visit copayment may apply.

Benefits chart – your covered services	What you must pay when you get these covered services
Colorectal screening *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *Requires prior authorization (approval in advance) to be covered.* *For people not at high risk of colorectal cancer, the following is covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. *Requires prior authorization (approval in advance) to be covered.*	There is no copayment for Medicare-covered colorectal screening exams. (See Outpatient surgery section for coverage of diagnostic colonscopies.) Doctor office visit copayment may apply.
Immunizations • Pneumonia vaccine (you must get this service from a Plan provider in your selected provider system). • Flu shots, once a year in the fall or winter (you must get this service from a Plan provider in your selected provider system). • *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. *Requires prior authorization (approval in advance) to be covered.* • Other vaccines if you are at risk. *Requires prior authorization (approval in advance) to be covered.*	There is no copayment for Medicare-covered immunizations. Doctor office visit copayment may apply.
Mammography screening • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	There is no copayment for Medicare-covered screening mammograms. Doctor office copayment may apply.

Benefits chart – your covered services	What you must pay when you get these covered services
Pap smears, pelvic exams, and clinical breast exam • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months.	There is no copayment for Pap tests. Doctor office visit copayment may apply.
Prostate cancer screening exams *For men over age 50, the following are covered once every 12 months:* • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no copayment for Medicare-covered prostate cancer screening exams. Doctor office visit copayment may apply.
Cardiovascular disease testing Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact Member Services for information on how often we will cover these tests.	There is no copayment for cardiovascular screening blood tests. Doctor office visit copayment may apply.
Physical exams For members whose Medicare Part B coverage begins on or after January 1, 2005: A one-time physical exam within the first 6 months that you have Medicare Part B. Includes measurement of height, weight, and blood pressure; an electrocardiogram, education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests. **Please note that VIVA MEDICARE PLUS SELECT covers one routine physical exam every year from your PCP, including routine lab tests. See Routine Physical Exams in the Additional Benefits section for a description of benefits for yearly physical exams.**	You pay $5 for the physical exam from your PCP.

Benefits chart – your covered services	What you must pay when you get these covered services
Other Services	
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).	$50 per treatment for outpatient dialysis up to a maximum out-of-pocket cost to you of $500 per calendar year.

Benefits chart – your covered services	What you must pay when you get these covered services
Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare Parts A and B) *Requires prior authorization (approval in advance) to be covered.* "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by VIVA MEDICARE PLUS SELECT. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	You pay: • 20% for Medicare-covered drugs, including chemotherapy drugs and injectable drugs. There is a $2,000 limit per calendar year on the amount you pay for Medicare-covered drugs to treat cancer such as chemotherapy and chemotherapy support drugs. Coinsurance paid on new drugs with unclassified codes does not count toward the $2,000 limit. • You pay 100% for prescription drugs not covered by Original Medicare.

Benefits chart – your covered services	What you must pay when you get these covered services
Additional Benefits	
Dental services • Limited to one (1) oral exam including prophylaxis (teeth cleaning) every 12 months (excludes x-rays and other services). If you pay for these services out-of-pocket, a request for reimbursement, including a copy of your receipt, should be filed with VIVA MEDICARE PLUS SELECT in accordance with Section 7.	You pay: • $0 for routine teeth cleaning and exam one time every 12 months.
• Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. *Requires prior authorization (approval in advance) to be covered.*	For Medicare-covered dental services, you pay: • $100 for inpatient hospital care. • $100 for outpatient surgery. • $10 for each specialist visit. You pay 100% for other dental services not listed in this section.
Hearing services • Routine hearing tests up to one (1) test per calendar year. • Diagnostic hearing exams.	You pay: • $5 for each Personal Care Physician (PCP) visit. • $10 for each specialist visit. You pay 100% for hearing aids.

Benefits chart – your covered services	What you must pay when you get these covered services
Vision care	You pay:
• One (1) routine eye exam every 12 months from a Plan ophthalmologist or optometrist in your selected provider system. • Outpatient physician services for eye care. • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year*	• $10 for each routine eye exam. • $10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. If corrective lenses are required following cataract surgery, VIVA MEDICARE PLUS SELECT covers up to the Medicare allowable amount toward the cost of contact lenses or eyeglass lenses/frames. Coverage is limited to the first pair of eyeglasses or contact lenses following cataract surgery.	• $0 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). You pay any amount over the Medicare allowable amount.
• $100 toward eyewear (glasses, contacts, lenses, frames) once every 12 months if a plan ophthalmologist or optometrist writes the prescription. If you pay for prescription eyewear out-of-pocket, a request for reimbursement, including a copy of your receipt, should be filed with VIVA MEDICARE PLUS SELECT in accordance with Section 7.	• You pay any amount over $100.
Routine physical exams	You pay $5 for each exam from your PCP.
• One (1) routine physical exam including routine lab tests per calendar year from your PCP.	

Benefits chart – your covered services	What you must pay when you get these covered services
Health and wellness education programs	You pay:
• Member newsletter. • Disease Management Program (for members with congestive heart failure and chronic obstructive pulmonary disease). *Members must meet specific criteria to participate in the Disease Management Program. Contact Member Services at the telephone number on the cover of this booklet for more information.* • $20 per month toward membership dues if you regularly participate (at least once a month) in a contracted sports fitness program.	• $0 for the member newsletter or the disease management program. • You pay any amount over $20.

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call Member Services at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 9 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can *increase* your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2006). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a copayment or coinsurance, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2006) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2007.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Section 5 Medical care and services that are NOT covered (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by VIVA MEDICARE PLUS SELECT. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

What services are not covered by VIVA MEDICARE PLUS SELECT?

In addition to any exclusions or limitation described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered by VIVA MEDICARE PLUS SELECT:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that you get from non-plan providers or from Plan providers that are not in your selected provider system, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the Plan's service area, and care from non-plan providers that is arranged or approved by a Plan provider **and** VIVA HEALTH. See other parts of this booklet (especially Sections 2 and 3) for information about using Plan providers and the exceptions that apply.
3. Services received before your effective date of coverage or after your disenrollment date, including care for medical conditions arising prior to your disenrollment date, even if VIVA HEALTH authorized such services. In some cases, inpatient hospital care may be covered after your disenrollment date as described in Section 6. If you filed an appeal of a service denial prior to your disenrollment date and the denial is later overturned by the Independent Review Organization, the service you appealed will be covered after your disenrollment date.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary under Original Medicare plan standards unless otherwise listed as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.

6. Services received outside the service area *except* for care for a medical emergency, urgently needed care the need for which could not have been foreseen before leaving the service area, and out-of-area renal (kidney) dialysis services.

7. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).

8. Travel or transportation expenses *except* ambulance transportation in a medical emergency or when authorized in advance, as described under Ambulance services in Section 4.

9. All prescription medications, drug therapies, biotechnicals, biologicals, injectables and pharmacological regimens for outpatient treatment except in accordance with Original Medicare coverage guidelines. Any prescription medication not covered by Original Medicare is excluded. All over-the-counter medications are excluded.

10. Hepatitis A vaccine *except* when exposure to hepatitis A is known and documented.

11. Experimental or investigational medical and surgical procedures, products, regiments, treatments, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by VIVA HEALTH and Original Medicare to not be generally accepted by the medical community. See Section 6 for information about participation in clinical trials while you are a member of VIVA MEDICARE PLUS SELECT.

12. Services for the treatment of obesity including, but not limited to, surgery, weight reduction programs or medications, stomach staples, related supplies, medications and laboratory tests unless medically necessary and covered under Original Medicare.

13. Private duty nurses and nursing care on a full-time basis in your home.

14. Services or equipment for personal hygiene, convenience or comfort such as private accommodations in a hospital or skilled nursing facility (*unless* medically necessary or if semi-private accommodations are not available), barber or beauty services, guest services, telephones or televisions when hospitalized or in a skilled nursing facility, air conditioners, exercise equipment, housekeeping and similar incidental services and supplies.

15. Health related services that do not require continued administration by trained medical personnel and non-health related services including domiciliary care, respite care or rest cures, convalescent care, and homemaker services. Custodial care is not covered by VIVA MEDICARE PLUS SELECT *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

16. Charges imposed by immediate relatives or members of your household.

17. Meals delivered to your home.

18. All enteral feedings and over-the-counter nutritional and electrolyte supplements, *except* in accordance with Original Medicare coverage guidelines.

19. Unless medically necessary and covered under Original Medicare, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.

20. Expenses related to physical conditioning such as athletic training, bodybuilding, exercise, fitness, flexibility, or motivation and equipment or devices primarily used for sports-related activities including safety items.

21. Plastic or cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Excluded services include but are not limited to reformation of sagging skin, changes in appearance of any portion of the body, hair transplants, chemical face peels or abrasion of the skin, wigs, and prosthetic hair. Breast reduction is not covered unless Original Medicare criteria for determining medical necessity are met. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.

22. Services for or associated with implants *unless* made medically necessary by accidental injury or disease as described in Section 4. The removal or replacement of breast implants *except* when required by post mastectomy reconstruction.

23. Penile implants or other devices or treatments used to correct impotence or other sexual dysfunction, *except* in accordance with Original Medicare coverage guidelines.

24. Services associated with the removal of scars, tattoos, actinic changes, or as a treatment for acne including but not limited to salabrasion, chemosurgery or other skin abrasion procedures.

25. Routine dental care *except* for one (1) oral exam including prophylaxis (cleaning of the teeth) every 12 months. Fillings, dentures and other dental services including but not limited to removal or replacement of teeth, implants and braces, even if needed due to accidental injury, are not covered. Certain dental services that you get when you are in the hospital may be covered.

26. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.

27. Routine foot care is generally not covered under the Plan and is limited according to Original Medicare guidelines.

28. Supportive devices for the feet, shoe inserts, shoe lifts, and orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. *There is an exception:* therapeutic shoes and inserts are covered according to Original Medicare guidelines for people with severe diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Diabetes self-monitoring, training and supplies").

29. Non-durable medical supplies including but not limited to elastic stockings, ace bandages, incontinence supplies, and over-the-counter drugs and treatments.

30. Mental health and/or substance abuse services not covered according to Original Medicare guidelines or that are required by court order, unless such order is consistent with the assessment and treatment plan of VIVA HEALTH or its designee. Examples of excluded therapy or counseling include counseling for personal, family, or marriage problems and therapy related to learning, for perceptual disorders, or for behavioral treatment, and for mental illnesses not usually amendable to favorable modification or not expected to substantially improve beyond the current level of functioning. Nutritional-based therapy for alcoholism or other chemical dependency.

31. Charges incurred in connection with the purchase or fitting of hearing aids.

32. Radial keratotomy, LASIK surgery, refractive eye surgery, vision therapy, eye exercises, visual training orthoptics, shaping the cornea with contact lenses, contact lens fitting fees, and other low vision aids and services including prescription and non-prescription glasses and contact lenses *except* eye wear following cataract surgery in accordance with Original Medicare coverage guidelines as outlined in Section 4.

33. Reversal of sterilization procedures and sex change operations. Contraceptive supplies and devices, including subcutaneous implants. Elective hysterectomy, tubal ligation, and vasectomy are also excluded if the reason for these procedures is sterilization.

34. Infertility services and supplies *except* in accordance with Original Medicare coverage guidelines whether on an inpatient or outpatient basis. Excluded services include but are not limited to in vitro fertilization, gamete intrafallopian transfer (GIFT), zygot intrafallopian transfer (ZIFT), preservation and storage of sperm, eggs, or embryos, menotropins and drug therapies, costs related to donor sperm or surrogate parenting, micro-manipulation procedures, embryo transport, and non-medically necessary amniocentesis.

35. Genetic testing and gene therapy.

36. Abortions, except in accordance with Original Medicare coverage guidelines.

37. Services for pregnancy and/or delivery outside the service area after the 35th week of pregnancy.

38. Health-related education (including prenatal classes) except from a Plan provider in the course of treatment, or in accordance with Original Medicare coverage guidelines.

39. Services for or related to acupuncture, accupressure, Christian Science practitioners' services, Naturopaths' services, hypnotism, hypnotherapy, holistic medicine, psychosurgery, megavitamin therapy, massage therapy, aroma therapy, Rolfing, and other forms of alternative treatment and self-help training.

40. Services for the removal of an organ from a member for purposes of transplantation into another person and services for transplants involving mechanical or animal organs. Only those transplants specified in Section 4 (Inpatient hospital care) are covered services.

41. High dose chemotherapy and related services involving the removal and subsequent return of blood cells except in accordance with Original Medicare coverage guidelines.

42. Services for which benefits are available if a proper claim were made by workers' compensation, occupational disease law or similar legislation. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under VIVA MEDICARE PLUS SELECT, we will reimburse veterans for the difference. Members are still responsible for the VIVA MEDICARE PLUS SELECT cost-sharing amount.

43. Services that are not otherwise covered services under this Evidence of Coverage or under Original Medicare coverage guidelines for obtaining or maintaining employment, insurance, or a license of any type or related to career, travel, education, judicial or administrative proceedings, medical research, marriage, or adoption, including but not limited to physical, psychiatric, or psychological examinations, and medical report preparation or presentation.

44. Fees charged for missed appointments and similar fees or penalties.

45. Hospice services in a Medicare-certified hospice and services covered by Original Medicare beginning on the first day of the month after the month you enroll in hospice are not paid for by VIVA MEDICARE PLUS SELECT, but are reimbursed directly by Original Medicare when you enroll in a Medicare-certified hospice.

46. Any health care item or service for the purpose of causing, or assisting to cause death.

47. Services required as a result of participation in a riot or in the commission of any assault or felony or required while incarcerated in a prison, jail, or other penal institution.

48. Services received as a result of war, whether declared or undeclared, or during service in the armed forces of any country.

Section 6 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Except for emergency care, all hospital care must be provided by the hospital(s) in your selected provider system that appears on your VIVA MEDICARE PLUS SELECT member identification card. As shown in the Benefits Chart in Section 4, you must pay a $100 inpatient hospital copayment for each Medicare-covered stay in a Plan hospital.

See Section 13 for definition of Inpatient care.

What happens if you join or drop out of VIVA MEDICARE PLUS SELECT during a hospital stay?

If you either join or leave VIVA MEDICARE PLUS SELECT during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a Plan member.

What is a "hospitalist"?

A hospitalist is a physician who specializes in treating patients when they are in the hospital. Some PCPs use a hospitalist to coordinate a patient's care when he or she is admitted to a VIVA MEDICARE PLUS SELECT hospital. PCPs who use hospitalists are identified in the provider directory.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services.** It can be a separate facility, or part of a hospital or other health care facility. A skilled nursing facility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by VIVA MEDICARE PLUS SELECT unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered SNF. The benefit period ends when you have not been an inpatient at any SNF for 60 days in a row. If you go to the SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. You will pay $0 each day for days 1-14 in a SNF. You will pay $75 each day for days 15-28. You will pay $0 each day for days 29-100. There is a $1,050 maximum out-of-pocket limit every year. No prior hospital stay is required.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

In some situations, you may be able to get care in a SNF that is not a Plan provider

Generally, you will get your skilled nursing facility care from SNFs that are Plan providers in your selected provider system for VIVA MEDICARE PLUS SELECT. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a Plan provider. One of the conditions is that the SNF that is not a Plan provider must be willing to accept VIVA HEALTH's rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or drop out of VIVA MEDICARE PLUS SELECT during a SNF stay?

If you either join or leave VIVA MEDICARE PLUS SELECT during a SNF stay, special rules apply to your coverage for the stay and to what you owe for the stay. If this situation applies to you, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to VIVA MEDICARE PLUS SELECT, if anything, for the periods of your stay when you were and were not a Plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also leave to go to an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of

supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program and must be a Plan provider in your selected provider system.
4. You must need *at least one* of the following types of skilled care:

   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of VIVA MEDICARE PLUS SELECT, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call the Medicare program at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048) to get a list of the Medicare-certified hospice providers in your area. You can call the Medicare helpline 24 hours a day, 7 days a week.

If you enroll in a Medicare-certified hospice, Original Medicare (rather than VIVA MEDICARE PLUS SELECT) pays the hospice for the hospice services you receive. Your hospice doctor can be a Plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a Plan member and continue to get the rest of your care that is unrelated to your terminal condition through VIVA MEDICARE PLUS SELECT. If you use non-plan providers for your routine care, Original Medicare (rather than VIVA MEDICARE PLUS SELECT) will cover your care and you will have to pay Original Medicare out-of-pocket amounts. If you use Plan providers for Medicare-covered services unrelated to the terminal condition starting the first day of the month after the month that you elect hospice, Original Medicare will pay for your care. VIVA MEDICARE PLUS SELECT will pay the balance minus your VIVA MEDICARE PLUS SELECT copayments and coinsurance.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare helpline, or visit the Medicare website at www.medicare.gov. The Medicare helpline is available 24 hours a day, 7 days a week. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a contracted, Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants. You pay 20% up to a maximum out-of-pocket cost to you of $3,000 per transplant procedure.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not VIVA MEDICARE PLUS SELECT) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in VIVA MEDICARE PLUS SELECT and continue to get the rest of your care that is unrelated to the clinical trial through VIVA MEDICARE PLUS SELECT . You will have to pay the Original Medicare coinsurance for the clinical trial services. The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You do *not* need to get a referral from a Plan provider to join a clinical trial, and the clinical trial providers do *not* need to be Plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by VIVA MEDICARE PLUS SELECT under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from VIVA MEDICARE PLUS SELECT, or your stay in the RNHCI may not be covered.

Section 7 What you must pay for your Medicare health plan coverage and for the care you receive

To be a member of VIVA MEDICARE PLUS SELECT, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member.

Paying your share of the cost when you get covered services

What are "copayments" and "coinsurance"?

- A **"copayment"** is a payment you make for your share of the cost of certain covered services you receive. A copayment is **a set amount per service** (such as paying $5 for a PCP office visit). You pay it when you get the service. The Benefits Chart in Section 4 gives your copayments for covered services.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services or supplies you receive. Coinsurance is **a *percentage* of the cost of the service** (such as paying 20% for each Medicare-covered durable medical equipment item). You pay your coinsurance when you get the service or supply. The Benefits Chart in Section 4 gives your coinsurance for covered services.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by VIVA MEDICARE PLUS SELECT. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a Plan member. With few exceptions, you must pay for services you receive from providers who are not part of your VIVA MEDICARE PLUS SELECT provider system unless VIVA HEALTH has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services, and services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using Plan providers in your selected provider system and the exceptions that apply.)

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** For example, VIVA MEDICARE PLUS SELECT covers 100 days (in a benefit period) of inpatient care in a participating skilled nursing facility (if the stay is prior authorized/approved in advance by the Plan). If you remain in a skilled nursing facility beyond the 100 days approved by the Plan, you have to pay the full cost of the care that you receive while you are in the skilled nursing facility. You can call Members Services when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides VIVA MEDICARE PLUS SELECT, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides VIVA MEDICARE PLUS SELECT, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of VIVA MEDICARE PLUS SELECT with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through VIVA MEDICARE PLUS SELECT, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by VIVA MEDICARE PLUS SELECT, you may get your care outside of VIVA MEDICARE PLUS SELECT.

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer.**" Then the other company or companies that are involved – called the "**secondary payers**" – each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this

payment to us. When you have additional health insurance, **whether we pay first or second – or at all – depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

VIVA MEDICARE PLUS SELECT has all the rights to recovery from other source of payment as Original Medicare. Reimbursement rights for VIVA MEDICARE PLUS SELECT are based on the covered services provided to the member and on the VIVA MEDICARE PLUS SELECT fee schedule. This fee schedule is to be used to calculate the amounts regardless of VIVA HEALTH's arrangements with any Plan provider.

If you have additional health insurance, please call Member Services at the telephone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First.* You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the Plan's service area, care that has been approved in advance by VIVA MEDICARE PLUS SELECT, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at the telephone number listed on the cover of this booklet or at 1400 21st Place South, Birmingham, AL 35205. It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received if you had been covered with Original Medicare.

How can I get reimbursed for covered services that I have paid for?

If you pay (out of your own pocket) for a covered service or supply instead of having the provider bill VIVA MEDICARE PLUS SELECT, you must file for reimbursement from VIVA MEDICARE PLUS SELECT within one year of the date you received the service or supply. VIVA MEDICARE PLUS SELECT will reimburse you for our share of the cost. You will still be responsible for any copayment or coinsurance that applies (if any). You should send your receipt for reimbursement to:

VIVA MEDICARE PLUS SELECT
Attn: Medicare Claims Department
1400 21st Place South
Birmingham, Alabama 35205

Please be sure that your receipt includes your name and member ID number (listed on your VIVA Medicare Plus Select ID card).

Section 8 Your rights and responsibilities as a member of VIVA MEDICARE PLUS SELECT

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of VIVA MEDICARE PLUS SELECT. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. VIVA HEALTH must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number on the cover of this booklet. Member Services can also help if you need to file a complaint about access (such as wheel chair access).

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this Plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care, paying for your care, or involved in administering your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. VIVA HEALTH's notice of health information practices can be found in Section 12. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask Plan providers to make additions or corrections to your medical records (if you ask Plan providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have

questions or concerns about privacy of your personal information and medical records, please call Member Services at the telephone number on the cover of this booklet.

Your right to see Plan providers and get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from Plan providers in your selected provider system, that is, from doctors and other health providers who are part of VIVA MEDICARE PLUS SELECT and who are in the provider system with your PCP. You have the right to choose a Plan provider (we will tell you which doctors are accepting new patients). You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use Plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by VIVA MEDICARE PLUS SELECT. This includes the right to know about the different Medication Management Treatment Program we offer. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a Plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Sections 9 and 10.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to

make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as the Alabama Department of Senior Services. Section 1 of this booklet tells how to contact the Alabama Department of Senior Services. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the Alabama Board of Medical Examiners at 1-800-227-2606 (calls to this number are free).

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals that involve your Medicare health benefits under VIVA MEDICARE PLUS SELECT are discussed in Sections 9 and 10.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* VIVA MEDICARE PLUS SELECT in the past. To get this information, call Member Services at the telephone number on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a Plan member and what you have to pay. If you need more information, please call Member Services at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by VIVA MEDICARE PLUS SELECT. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 9 and 10 for more information about filing an appeal.

Your right to get information about VIVA HEALTH, VIVA MEDICARE PLUS SELECT, Plan providers and costs

You have the right to get information from us about VIVA HEALTH and VIVA MEDICARE PLUS SELECT. This includes information about our financial condition, about our health care providers and their qualifications, and about how VIVA MEDICARE PLUS SELECT compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the telephone number on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number on the cover of this booklet. You can also get free help and information from the Alabama Department of Senior Services (Section 1 tells how to contact the Alabama Department of Senior Services). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the web to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 1-800-368-1019 (calls to this number are free).
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number on the cover of this booklet. You can also get help from the Alabama Department of Senior Services (Section 1 tells how to contact the Alabama Department of Senior Services).

What are your responsibilities as a member of VIVA MEDICARE PLUS SELECT?

Along with the rights you have as a member of VIVA MEDICARE PLUS SELECT, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the telephone number on the cover of this booklet if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. This includes showing your VIVA MEDICARE PLUS SELECT membership ID card. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay any copayments and coinsurance you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 7 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the telephone number on the cover of this booklet.
- To tell VIVA MEDICARE PLUS SELECT if your address or telephone number changes.
- To call VIVA Medicare Plus Select if you are admitted to a non-plan hospital.

Section 9 Appeals and grievances: What to do if you have complaints about your Medicare Advantage benefits

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Member Services at the number on the cover of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a Plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from VIVA MEDICARE PLUS SELECT or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

- An **"appeal"** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit**. For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If VIVA MEDICARE PLUS SELECT or one of our Plan providers refuses to give you a service you think should be covered, you can file an appeal. If VIVA MEDICARE PLUS SELECT or one of our Plan providers reduces or cuts back on services or benefits you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service or benefit too soon, you can file an appeal.
- **A "grievance"** is the type of complaint you make **if you have any other type of problem with** VIVA MEDICARE PLUS SELECT **or one of our Plan providers.** For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by telephone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Complaints about what we will cover for you or what we will pay for.** If VIVA MEDICARE PLUS SELECT or your doctor or another Plan provider has refused to give you a service you think is covered, you can make a complaint called an **appeal**. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).

2. **Complaints if you think you are being discharged from the hospital too soon**. There is a special type of **appeal** that applies only to **hospital discharges**. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to the Alabama Quality Assurance Foundation, which is the Quality Improvement Organization in the State of Alabama. The Alabama Quality Assurance Foundation is a group of health professionals in Alabama that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the Alabama Quality Assurance Foundation uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

3. **Complaints if you think your coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.** There is another special type of **appeal** that applies only when coverage will end for **SNF, HHA or CORF services**. If you think your coverage is ending too soon, you can appeal directly and immediately to the Alabama Quality Assurance Foundation. If you make this type of appeal, your stay may be covered during the time period the Alabama Quality Assurance Foundation uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

4. **Complaints about any other type of problem you have with VIVA MEDICARE PLUS SELECT or one of our Plan providers.** If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by telephone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with VIVA MEDICARE PLUS SELECT. But for many problems related to quality of care you get from Plan providers, you can also complain to the Alabama Quality Assurance Foundation.

Part 1. Complaints (called "appeals") to VIVA MEDICARE PLUS SELECT to change a decision about what services we will cover or what we will pay for

This part of Section 9 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word "provide" in a general way to include such

things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by VIVA MEDICARE PLUS SELECT.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by VIVA MEDICARE PLUS SELECT.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by VIVA MEDICARE PLUS SELECT while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from VIVA MEDICARE PLUS SELECT:

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 10):

Step 1: The initial decision by VIVA MEDICARE PLUS SELECT

The starting point is when we make an "initial decision" (also called an "organization determination") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of VIVA MEDICARE PLUS SELECT apply to your specific situation. As explained in Section 10, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

Step 2: Appealing the initial decision by VIVA MEDICARE PLUS SELECT

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for reconsideration." As explained in Section 10, you can ask for a "fast appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to

stay with our original decision, or change this decision and give you some or all of the care or payment you want.

Step 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of VIVA MEDICARE PLUS SELECT. This organization will review your request and make a decision about whether we must give you the care or payment you want.

Step 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $110 to be considered in Step 4.

Step 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a Medicare Appeals Council to review your case. This Council is part of the federal department that runs the Medicare program.

Step 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must at least $1,090 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 10.

Part 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by VIVA MEDICARE PLUS SELECT that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 9 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.

- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

Review of your hospital discharge by the Alabama Quality Assurance Foundation

If you think that you are being discharged too soon, ask VIVA MEDICARE PLUS SELECT to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have told VIVA MEDICARE PLUS SELECT that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Alabama Quality Assurance Foundation to review whether your discharge is medically appropriate.

What is the "Alabama Quality Assurance Foundation"?

The Alabama Quality Assurance Foundation is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of VIVA MEDICARE PLUS SELECT or your hospital. The doctors and other health experts in the Alabama Quality Assurance Foundation review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the Alabama Quality Assurance Foundation.

Getting an Alabama Quality Assurance Foundation review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the Alabama Quality Assurance Foundation. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of the Alabama Quality Assurance Foundation and tells you what you must do.

- You must ask the Alabama Quality Assurance Foundation for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.

- You must be sure that you have made your request to the Alabama Quality Assurance Foundation **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the Alabama Quality Assurance Foundation (see below).

If the Alabama Quality Assurance Foundation reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The Alabama Quality Assurance Foundation will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the Alabama Quality Assurance Foundation decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the Alabama Quality Assurance Foundation gives you its decision.
- If the Alabama Quality Assurance Foundation agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the Alabama Quality Assurance Foundation for a review by the deadline?

You still have another option: asking VIVA MEDICARE PLUS SELECT for a "fast appeal" of your discharge

If you do not ask the Alabama Quality Assurance Foundation for a "fast review" ("fast appeal") of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 10.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will **not** cover any hospital care you received if you stayed in the hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask for immediate review by the Alabama Quality Assurance Foundation, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 10.

Part 3. Complaints (called "appeals") if you think your coverage for SNF, home health, or comprehensive outpatient rehabilitation facility services are ending too soon.

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by VIVA MEDICARE PLUS SELECT that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 9 explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to get a review of your coverage by the Alabama Quality Assurance Foundation

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Alabama Quality Assurance Foundation to do an independent review of whether our terminating your coverage is medically appropriate.

How soon do you have to ask the Alabama Quality Assurance Foundation to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact the Alabama Quality Assurance Foundation. The written notice you got from us or your provider gives the name and telephone number of the Alabama Quality Assurance Foundation and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** of the day before the date that your coverage ends.

What will happen during the review?

If the Alabama Quality Assurance Foundation reviews your case, the Alabama Quality Assurance Foundation will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The Alabama Quality Assurance Foundation will also look at your medical information, talk to your doctor, and review other information that we have given them. You and the Alabama Quality

Assurance Foundation will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the Alabama Quality Assurance Foundation will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The Alabama Quality Assurance Foundation will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the Alabama Quality Assurance Foundation decides in your favor?

If the Alabama Quality Assurance Foundation agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary or until your benefits are exhausted (SNF is limited to 100 days each benefit period).

What happens if the Alabama Quality Assurance Foundation denies your request?

If the Alabama Quality Assurance Foundation decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor VIVA MEDICARE PLUS SELECT will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the Alabama Quality Assurance Foundation for a review in time?

You still have another option: asking VIVA MEDICARE PLUS SELECT for a "fast appeal" of your discharge.

If you do not ask the Alabama Quality Assurance Foundation for a "fast appeal" of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 10.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary or until your benefits are exhausted (SNF is limited to 100 days each benefit period).
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date.

If you do not ask the Alabama Quality Assurance Foundation by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA or CORF services, and if you stay in the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care you receive on and after this date. However, you can appeal any

bills for SNF, HHA or CORF care you receive using Step 1 of the appeals process described in Section 10.

Part 4. Complaints (called "grievances") about any other type of problem you have with VIVA MEDICARE PLUS SELECT or one of our Plan providers

This last part of Section 9 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems about being discharged from the hospital too soon and problems about coverage for SNF, HHA, or CORF services ending to soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) VIVA MEDICARE PLUS SELECT.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the telephone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with VIVA MEDICARE PLUS SELECT

If you have a complaint, we encourage you to first call Member Services at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the VIVA MEDICARE PLUS SELECT grievance procedure.

Grievances are processed according to the grievance procedure set forth below. VIVA MEDICARE PLUS SELECT may revise the grievance procedure from time to time. The grievance procedure consists of the following levels of review:

A. **Inquiry.** Questions or requests resulting from normal/routine business operations that can be resolved to your satisfaction are classified as inquires. Examples of such inquires include questions regarding the status of a claim, clarification of benefits, requests for membership ID cards, address changes, etc. The easiest way for you to make an inquiry to VIVA MEDICARE PLUS SELECT is by simply calling Member Services at the telephone number on the cover of this booklet. Talking with Member Services often helps avoid the need for written grievances and formal meetings. Inquires can also be conducted in writing or in person. VIVA MEDICARE PLUS SELECT will try to resolve any problems to your satisfaction in a timely manner. If you have an inquiry that is not resolved to your satisfaction, you will be informed of the informal grievance procedure available to you or your authorized representative.

B. **Informal Grievance.** Issues not resolved to your satisfaction at the inquiry level are classified as informal grievances. You can file an informal grievance by calling the Member Services Department at the telephone number on the cover of this booklet or by writing to VIVA MEDICARE PLUS SELECT, Attention: Medicare Member Appeals and Grievances Coordinator, 1400 21st Place South, Birmingham, AL 35205. You can also fax your informal grievance to us at 205-939-1748. If you express dissatisfaction with the resolution of an inquiry, VIVA MEDICARE PLUS SELECT will automatically elevate your inquiry to an informal grievance.

   Informal grievances must be made verbally or in writing no later than 60 days after the event or incident took place. VIVA MEDICARE PLUS SELECT will issue a decision regarding the informal grievance as expeditiously as your situation requires, but no later than 30 days from receipt of the informal grievance. VIVA MEDICARE PLUS SELECT may extend the 30-day time frame by up to 14 days if you request the extension or if we justify a need for additional information that could benefit you. If we extend the time frame for making a decision, we will notify you in writing.

   If you file an informal grievance regarding our refusal to give you a "fast" review of a coverage determination or redetermination (appeal), or regarding our decision to take a 14-day extension (as explained above), we will make our informal grievance decision within 24 hours from receipt of the informal grievance.

   If the issue is not resolved to your satisfaction at this level, you have a right to a second review by filing a formal grievance (described below).

C. **Formal Grievance.** Issues not resolved to your satisfaction at the informal grievance level in which you express a subsequent written expression regarding the resolution of an informal grievance are classified as formal grievances. A formal grievance must be filed in writing within 12 months of our receipt of the original informal grievance. VIVA MEDICARE PLUS SELECT may allow an extension of the 12 month limit due to extenuating circumstances. Formal grievances may be submitted by written letter or using a formal grievance form available from VIVA MEDICARE PLUS SELECT. The formal grievance should be mailed to: VIVA MEDICARE PLUS SELECT, Attention: Medicare Member Appeals and Grievances

Coordinator, 1400 21st Place South, Birmingham, AL 35205. You can also fax your formal grievance to us at 205-939-1748.

A provider may act on your behalf in the formal grievance process if the provider certifies in writing to VIVA MEDICARE PLUS SELECT that you are unable to act on your own behalf due to illness or disability. A family member, friend, provider, or any other person may act on your behalf after VIVA MEDICARE PLUS SELECT receives your written appointment of the individual to act as your representative. You also have the right to request that a VIVA MEDICARE PLUS SELECT staff member assist you with the formal grievance.

The Formal Grievance Committee reviews all formal grievances. You or any other party of interest may provide pertinent information to the Formal Grievance Committee in person or in writing. The Formal Grievance Committee issues its decision as expeditiously as the situation requires but no later than thirty (30) days from receipt of the formal grievance. You are given written notification regarding the Formal Grievance Committee's decision within five (5) business days of the decision being made. The written notice will include your right to a third level review by the State Health Officer or the Alabama Insurance Commissioner.

D. **Third Level Review.** You may file a written grievance to the State Health Officer or the Alabama Insurance Commissioner when you are dissatisfied with the VIVA MEDICARE PLUS SELECT grievance review procedures or the way such procedures were carried out.

For quality of care problems, you may also complain to the Alabama Quality Assurance Foundation

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to the Alabama Quality Assurance Foundation. See Section 1 for more information about the Quality Assurance Foundation.

Section 10 Detailed information about how to make an appeal that involves your Medicare Advantage benefits

What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 9). Section 9 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 9 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 9 before you read this section.**

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say "initial decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your appeal." We use "independent review organization" rather than "independent review entity."

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a Plan member. This includes payment for care received while a member of VIVA MEDICARE PLUS SELECT. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by VIVA MEDICARE PLUS SELECT.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by VIVA MEDICARE PLUS SELECT.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe is covered by VIVA MEDICARE PLUS SELECT, but we have refused to pay for this care because we say it is not covered.

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next.** At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.

- **"Initial decision" vs. "making an appeal."** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an "initial decision" or "organization determination." If you continue with your complaint by going on to Step 2, it is called making an "appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.

- **Who makes the decision at each step?** In Step 1, you or your health care provider make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision is to turn down your request, you can go on to Step 2, where you appeal this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of VIVA MEDICARE PLUS SELECT, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program or the federal court system.

Step 1: VIVA MEDICARE PLUS SELECT makes an "initial decision" about your medical care, or about paying for care you have already received

What is an "initial decision"?

The "initial decision" made by VIVA MEDICARE PLUS SELECT is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely "initial decision" on your request.

- If you ask us to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call us at the telephone number on the cover of this booklet to get help in making this request.

- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want is covered by VIVA MEDICARE PLUS SELECT. Depending on the situation, your doctor or other medical provider may make this decision on behalf of VIVA MEDICARE PLUS SELECT, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at the telephone number listed on the cover of this booklet to ask for an initial decision.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of VIVA MEDICARE PLUS SELECT apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by VIVA MEDICARE PLUS SELECT, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by VIVA MEDICARE PLUS SELECT).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Doctors or other medical providers can ask us for an initial decision on your behalf. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at 1400 21st Place South, Birmingham, Alabama 35205. You can call us at the telephone number on the cover of this booklet to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact Legal Services Alabama at 1-334-832-4570.

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days; see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address:

VIVA MEDICARE PLUS SELECT
1400 21st Place South
Birmingham, Alabama 35205

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at 1-800-633-1542 toll free (Monday through Friday, 8 a.m. to 5 p.m.). After regular business hours, the answering service will have someone call you back. TTY users should call the Alabama Relay Service at 1-800-548-2546. Or, you can fax it to 1-205-939-1748 or deliver a written request (Monday through Friday, 8 a.m. to 5 p.m.) to:

VIVA MEDICARE PLUS SELECT
1400 21st Place South
Birmingham, Alabama 35205

Be sure to ask for a "fast" or "72-hour" review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide, depends on the type of decision.

1. **For a decision about payment for care you already received.**

   We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. **For a <u>standard</u> initial decision about medical care.**

   We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "grievance." Section 9 of this booklet tells how to file a grievance.

   We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

   If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal.

3. **For a <u>fast</u> initial decision about medical care.**

   If you receive a "fast" review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review – sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "grievance." Section 9 of this booklet tells how to file a grievance.

   We will tell you our decision by telephone as soon as we make the decision. If we deny your request (completely or in part), then within three calendar days after we tell you of our decision in person or by telephone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 9 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. **For a decision about payment for care you already received.**

   We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. **For a standard decision about medical care.**

   We must authorize the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve your medical care when we make our decision.

3. **For a fast decision about medical care.**

   We must authorize the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must authorize it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2.)

Step 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for reconsideration."

Please call us at the telephone number on the cover of this booklet if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to VIVA MEDICARE PLUS SELECT, Attention: Medicare Member Appeals and Grievances Coordinator, 1400 21st Place South, Birmingham, AL 35205.
- By fax, at 1-205-939-1748.
- By telephone – if it is a "fast" appeal – at 1-800-633-1542 toll free. TTY users should call the Alabama Relay Service at 1-800-548-2546 (Monday through Friday, 8 a.m. to 5 p.m.).
- In person, at 1400 21st Place South, Birmingham, AL 35205.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-633-1542 toll free; TTY users should call the Alabama Relay Service at 1-800-548-2546 (Monday through Friday, 8 a.m. to 5 p.m.); VIVA MEDICARE PLUS SELECT, 1400 21st Place South, Birmingham, AL 35205. We are allowed to charge a fee for copying and sending this information to you.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Follow the instructions in Step 1 under "Who may ask for an 'initial decision'" about medical care or payment?"

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with VIVA MEDICARE PLUS SELECT must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at VIVA MEDICARE PLUS SELECT, Attention: Medicare Member Appeals and Grievances Coordinator, 1400 21st Place South, Birmingham, AL 35205, within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal in Step 2 are the same as the rules about asking for a "fast" initial decision in Step 1. If you want to ask for a "fast" appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision."

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. For a decision about payment for care you already received.

After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. For a standard decision about medical care.

After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which may help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

3. For a fast decision about medical care.

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which may help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. For a decision about payment for care you already received.

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. For a standard decision about medical care.

We must authorize the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize the care you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of VIVA MEDICARE PLUS SELECT. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. **For a decision about payment for care you already received.**

   We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. **For a standard decision about medical care.**

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2 (or by the end of the extended time period if an extension was taken).

3. **For a fast decision about medical care.**

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Step 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization.

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. **For an appeal about payment for care**, the independent review organization has up to 60 calendar days to make a decision.

2. **For a standard appeal about medical care**, the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension may benefit you.

3. **For a fast appeal about medical care**, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension may benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For an appeal about payment for care,** we must pay within 30 calendar days after receiving the decision.
2. **For a standard appeal about medical care**, we must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.
3. **For a fast appeal about medical care**, we must authorize the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is $110 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You can send your written request for review by an Administrative Law Judge directly to the independent review organization that reviewed your appeal in Step 3, or to VIVA MEDICARE PLUS SELECT. The independent review organization or VIVA MEDICARE PLUS SELECT will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

Step 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by counsel. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than $110. If the dollar value is less than $110, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for or authorize the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

Step 5: Your case may be reviewed by a Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or VIVA MEDICARE PLUS SELECT may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,090 or more. If the dollar value is less than $1,090, you may not appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for or authorize the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,090. If the dollar value is less than $1,090, the Council's decision is final.

If the Council decides against you

If the amount involved is $1,090 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,090, the Council's decision is final and you may not take the appeal any further.

Step 6: Your case may go to a Federal Court

If the contested amount is $1,090 or more, you or we may ask a Federal Court Judge to review the case.

Section 11 Leaving VIVA MEDICARE PLUS SELECT and your choices for continuing Medicare after you leave

What is "disenrollment"?

"Disenrollment" from VIVA MEDICARE PLUS SELECT means **ending your membership** in VIVA MEDICARE PLUS SELECT. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave VIVA MEDICARE PLUS SELECT because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to when you may leave, how often you can make changes, and what type of plan you can join after you leave.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave VIVA MEDICARE PLUS SELECT if you move permanently out of our geographic service area or if VIVA MEDICARE PLUS SELECT leaves the Medicare program. We are not allowed to ask you to leave the Plan because of your health.

Whether leaving the Plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership ends, you must keep getting your Medicare services through VIVA MEDICARE PLUS SELECT or you will have to pay for them yourself

If you leave VIVA MEDICARE PLUS SELECT, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through VIVA MEDICARE PLUS SELECT.

If you get services from doctors or other medical providers who are **not** Plan providers or are not in your selected provider system before your membership in VIVA MEDICARE PLUS SELECT ends, neither VIVA MEDICARE PLUS SELECT nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services at the number on the cover of this booklet to find out if your hospital care will be covered by VIVA MEDICARE PLUS SELECT. If you have any questions about leaving VIVA MEDICARE PLUS SELECT, please call Member Services.

What are your choices for receiving your Medicare services if you leave VIVA MEDICARE PLUS SELECT?

- If you leave VIVA MEDICARE PLUS SELECT, one choice for continuing with Medicare is to join a **Medicare Advantage Plan or other Medicare Health Plan** *if* any of these types of plans are available in your area, and if they are accepting new members. You can also choose the **Original Medicare plan.** If you choose Original Medicare, you must choose a Prescription Drug Plan if you wish to have Medicare prescription drug coverage.

- **Original Medicare** is available throughout the country. It is a "fee-for-service" health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Then Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). If you choose Original Medicare and you want to get Medicare prescription drug coverage, you will need to enroll in one of the **Prescription Drug Plans** that are available in your area. These plans only cover prescription drugs (not other benefits or services). If you switch to Original Medicare between January 1, 2006 and June 30, 2006 (see "When and how often can you change your Medicare choices, and what choices can you make?" below), you may be required to join one of these plans if you join Original Medicare.

- **Other Medicare Advantage Plans** (including HMO plans such as VIVA MEDICARE PLUS SELECT or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. VIVA MEDICARE PLUS SELECT is a Medicare Advantage Plan without prescription drug coverage offered by VIVA HEALTH.

- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it pays and what you pay – for the services you will get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. (See "When and how often can you change your Medicare choices, and what choices can you make?"). Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

When and how often can you change your Medicare choices, and what choices can you make?

Starting in 2006, there are limits to when and how often you can change the way you get Medicare and what choices you can make when you make the change.

Here are the new rules:

1. From November 15, 2005 through May 15, 2006, anyone with Medicare will have two chances to switch from one way of getting Medicare to another.

2. From January 1, 2006 until June 30, 2006, anyone with Medicare has another chance to make one change in the way they get Medicare.

With this chance, you are limited in the type of plan you may join. If you have Medicare prescription drug coverage when making your change, you will only be able to join a Medicare Advantage Plan or Medicare Private Fee-For-Service plan that offers the Medicare Part D (Prescription Drug benefit), or you will have to go to Original Medicare and join a Prescription Drug Plan. If you do not have Medicare prescription drug coverage when making this change, you will only be able to join a Medicare Advantage Plan or Private Fee-For-Service plan that does not offer the Medicare Part D (Prescription Drug benefit), or go to Original Medicare.

3. Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move, or if you have Medicaid coverage (contact us for information). Later in the year, from November 15 through December 31, 2006, anyone with Medicare can switch their way of getting Medicare to another way for the following year.

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1.

What should you do if you decide to leave VIVA MEDICARE PLUS SELECT?

If you want to leave VIVA MEDICARE PLUS SELECT:

- The first step is to **be sure that the type of change you want to make and when you want to make it fit with the new rules** explained above about changing how you get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.
- Then, what you must do to leave VIVA MEDICARE PLUS SELECT depends on whether you want to switch to Original Medicare or to one of your other choices.

How to change from VIVA MEDICARE PLUS SELECT to Original Medicare

Do you need to join a Prescription Drug Plan?

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from VIVA MEDICARE PLUS SELECT to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan. It is important to know that if you are eligible to join a prescription drug plan and you do not, you may have to pay a higher premium when you do join. To get information about Prescription Drug Plans that you

can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare helpline. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from VIVA MEDICARE PLUS SELECT to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact the Alabama Department of Senior Services (the telephone number is in Section 1). You can ask the Alabama Department of Senior Services about how and when to buy a Medigap policy if you need one. The Alabama Department of Senior Services can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our Plan while you are still in your open enrollment period, and you do not have a guaranteed issue right, the Medigap insurer can refuse to sell you a policy, or impose limits based on your health. If you have a "**guaranteed issue right,**" this means that for a limited period the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare, in certain situations you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period. You may be in a trail period if, in the past 12 months you: (1) dropped a Medigap policy to join VIVA MEDICARE PLUS SELECT or another Medicare health plan for the first time; or (2) joined VIVA MEDICARE PLUS SELECT or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. The Alabama Department of Senior Services can tell you about other situations where you may have guaranteed issue rights. You may also have a guaranteed issue right if you move out of our service area, or if we stop providing Medicare benefits.

If you do want to buy a Medigap policy, you have to follow the instructions below for changing from VIVA MEDICARE PLUS SELECT to Original Medicare. (Buying a Medigap policy does not switch you from VIVA MEDICARE PLUS SELECT to Original Medicare. In fact, while you are still enrolled in VIVA MEDICARE PLUS SELECT it is against the law for a Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your VIVA MEDICARE PLUS SELECT membership and put you in Original Medicare.)

How to change from VIVA MEDICARE PLUS SELECT to Original Medicare

If you decide to change from VIVA MEDICARE PLUS SELECT to Original Medicare, you must tell us or Medicare that you want to leave VIVA MEDICARE PLUS SELECT. You do *not* have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave VIVA MEDICARE PLUS SELECT. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave VIVA MEDICARE PLUS SELECT:

- You can write or fax a letter to us or fill out a disenrollment form and send it to Member Services at 1400 21st Place South, Birmingham, AL 35205 or to our fax number at (205) 939-1748. Be sure to sign and date your letter or disenrollment form. To get a disenrollment form, call us at the telephone number on the cover of this booklet.
- You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare helpline (calls to this number are free). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave VIVA MEDICARE PLUS SELECT. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. Remember, while you are waiting for your membership to end, you are still a member of VIVA MEDICARE PLUS SELECT and must continue to get your medical care as usual through VIVA MEDICARE PLUS SELECT.
3. On your disenrollment date, your membership in VIVA MEDICARE PLUS SELECT ends and you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave VIVA MEDICARE PLUS SELECT. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from VIVA MEDICARE PLUS SELECT to another Medicare Advantage Plan or to a Private Fee-for-Service Plan

If you want to change from VIVA MEDICARE PLUS SELECT to a different Medicare Advantage plan, including a Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members. See "When and how often can you change your Medicare choices, and what choices can you make?"
2. **Once you are enrolled in your new plan, your VIVA MEDICARE PLUS SELECT will *automatically* end.** This means that you do not need to tell us that you are leaving. However, we do encourage you to tell us why you left.
3. Your new plan will tell you the date when your membership in that plan begins, and your membership in VIVA MEDICARE PLUS SELECT will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through VIVA MEDICARE PLUS SELECT until the date your membership ends.

What happens to you if VIVA MEDICARE PLUS SELECT leaves the Medicare program or VIVA MEDICARE PLUS SELECT leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in VIVA MEDICARE PLUS SELECT will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through VIVA MEDICARE PLUS SELECT until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Medicare Advantage Plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from VIVA MEDICARE PLUS SELECT to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

VIVA MEDICARE PLUS SELECT has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either VIVA MEDICARE PLUS SELECT or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

You must leave VIVA MEDICARE PLUS SELECT if you move out of the service area or are away from the service area for more than six months in a row

If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in VIVA MEDICARE PLUS SELECT's service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of VIVA MEDICARE PLUS SELECT. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave VIVA MEDICARE PLUS SELECT and explains how to leave.

Under certain conditions VIVA MEDICARE PLUS SELECT can end your membership and make you leave the Plan

We *cannot* ask you to leave the Plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave VIVA MEDICARE PLUS SELECT because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare helpline. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We *can* ask you to leave the Plan under certain special conditions

If any of the following situations occur, we will end your membership in VIVA MEDICARE PLUS SELECT.

- If you move out of our geographic service area or live outside the Plan's service area for more than six months at a time (see Section 2 for information about the Plan's service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 7 for information about staying enrolled in Part A and Part B).
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in VIVA MEDICARE PLUS SELECT.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of VIVA MEDICARE PLUS SELECT. We cannot make you leave VIVA MEDICARE PLUS SELECT for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your Plan membership card to get medical care or prescription drugs. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

You have the right to make a complaint if we ask you to leave VIVA MEDICARE PLUS SELECT

If we ask you to leave VIVA MEDICARE PLUS SELECT, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

Section 12 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of Alabama may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like VIVA HEALTH, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Notice about privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Medical Information: This notice describes the health information practices of VIVA HEALTH. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: (1) make sure that medical information that identifies you is kept private, (2) give you this notice of our legal duties and privacy practices with respect to medical information about you, (3) follow the terms of the notice that is currently in effect.

How We May Use And Disclose Medical Information About You. The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. Any other uses and disclosures will be made only with your written authorization.

- **For Treatment and Treatment Alternatives**. For example, we may disclose medical information about you to your doctor for your treatment by him or use your medical information to tell you about health-related benefits or services that may be of interest to you.

- **For Payment**. For example, we may use and disclose medical information about you to process claims for covered health care services, to coordinate benefits with other benefit plans, to pursue recoveries from third parties, or to provide eligibility information to a health care provider.
- **For Health Care Operations**. For example, we may use and disclose medical information about you to conduct quality assessment and improvement activities, for underwriting, premium rating, or other activities relating to the issuing, renewal or replacement of a Group Policy, to engage in care coordination or case management, and to manage, plan or develop VIVA HEALTH's business.
- **Individuals Involved in Your Care or Payment for Your Care**. For example, we may disclose medical information about you to a friend or family member who is involved in your medical care or with payment for your health care and to your personal representatives appointed by you or designated by applicable law.
- **Business Associates.** There are some services provided by VIVA HEALTH through contracts with business associates. Examples include consultants, accountants, and lawyers. When services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your health information.
- **Employers**. VIVA HEALTH may disclose to the Employer (if any), in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. VIVA HEALTH may also disclose to the Employer the fact that you are enrolled in, or disenrolled from, VIVA HEALTH. VIVA HEALTH may disclose your medical information to the Employer for administrative functions that the Employer provides to VIVA HEALTH if the Employer agrees in writing to ensure the continuing confidentiality and security of your medical information. The Employer must also agree not to use or disclose your medical information for employment-related activities.
- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.
- **Certain Marketing Activities.** We may use medical information about you to forward promotional gifts of nominal value, to communicate with you about services offered by VIVA HEALTH, to communicate with you about case management and care coordination and to communicate with you about treatment alternatives.
- **Other Permitted Uses and Disclosures:**

- To public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- To a governmental agency authorized to oversee the health care system or government programs.
- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for law enforcement purposes as required by law.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- For research purposes in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.

- To appropriate military authorities, if you are a member of the armed forces.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes and so they may provide protection of the President or other authorized persons or foreign heads of state or conduct special investigations.
- To workers' compensation or similar programs providing benefits for work-related injuries or illness.
- To the correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official.

Your Rights Regarding Medical Information About You. You may make a written request to the Privacy Officer at the address at the end of this notice to do one or more of the following concerning your medical information we maintain:

- **Right to Inspect and Copy** medical information that may be used to make decisions about your care. In limited cases VIVA HEALTH does not have to agree to your request. We may charge a fee for the costs of copying, mailing or other supplies.
- **Right to Amend** if you feel that medical information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by VIVA HEALTH. You must provide a reason that supports your written request. We may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information we keep; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.
- **Right to an Accounting of Disclosures**. This is a list of the disclosures we made of medical information about you for reasons other than payment, treatment, or health care operations. Your written request must state a time period not longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions** or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In your written request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Request Confidential Communications** with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate reasonable requests to the extent possible. Your request must specify how or where you wish to be contacted. Even though you requested that we communicate with you in confidence, VIVA HEALTH may give subscribers cost information.

- **Right to Revoke Authorization** to use or disclose your medical information except to the extent that action has already been taken in reliance on your authorization.
- **Right to a Paper Copy of This Notice**. You may ask us to give you a paper copy of this notice at any time.

Changes To This Notice. We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If we make a material change to this notice, VIVA HEALTH will send a new notice to all subscribers covered by VIVA HEALTH at that time. **The currently effective notice will be posted on VIVA HEALTH's website at www.vivahealth.com at all times.**

For More Information Or To Report A Problem. If you have questions or would like additional information, you may contact VIVA HEALTH's Privacy Officer at 1400 21st Place South, Birmingham, AL 35205 or by e-mail at vivaprivacy@uabmc.edu or by telephone at 1-800-633-1542. For TTY services, please call the Alabama Relay Service at 1-800-548-2546. Office hours are Monday through Friday, 8 a.m. to 5 p.m. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer in writing at the address above or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Section 13 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 9 and 10 explain about appeals, including the process involved in making an appeal.

Benefit period – For VIVA MEDICARE PLUS SELECT, a benefit period is used to determine coverage for inpatient stays in skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered skilled nursing facility (SNF). The benefit period *ends* when you have not been an inpatient at any SNF for 60 days in a row. If you go to the SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 6 tells what is meant by skilled care.)

Calendar year – The period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by VIVA MEDICARE PLUS SELECT. Covered services are listed in the Benefits Chart in Section 4.

Disenroll or disenrollment – The process of ending your membership in VIVA MEDICARE PLUS SELECT. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about disenrollment.

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen, and other items that are determined medically necessary in accordance with Medicare law, regulations and guidelines.

Emergency care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Experimental procedures and items – Items and procedures determined by Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, VIVA HEALTH, Inc. will follow the Centers for Medicare & Medicaid Services' (CMS) manuals or will follow decisions already made by Medicare. Original Medicare may cover procedures and items under approved clinical trials. Experimental procedures and items are not covered under this Evidence of Coverage.

Grievance – A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 9 for more information about grievances.

Initial decision – The starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received.

Inpatient care – Health care that you get when you are admitted to a hospital.

Medically necessary – Those health care services determined by VIVA HEALTH to be necessary to meet your basic medical needs. VIVA HEALTH determines medical necessity on a case-by-case basis. In order to be considered medically necessary, services must be:

1. Consistent with the diagnosis and treatment of your condition, disease, ailment or injury and necessary and likely to be effective for treatment in a reasonably predictable period of time;

2. Appropriate with regard to standards of good medical practice;

3. Not solely for the convenience or comfort of you, your physician, hospital, or other health care provider; and

4. The most appropriate supply or level of service that can be provided to you.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. VIVA HEALTH is a Medicare Advantage Organization.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the plan. A Medicare Advantage Organization may offer more than one plan in the same service area. VIVA MEDICARE PLUS SELECT is a Medicare Advantage Plan.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare prescription drug coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. (Members enrolled in VIVA MEDICARE PLUS SELECT do not have prescription drug coverage *except* for those limited drugs covered by Medicare Part B.)

"Medigap" (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (member of VIVA MEDICARE PLUS SELECT, or "Plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in VIVA MEDICARE PLUS SELECT, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within VIVA HEALTH responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

Non-plan provider or non-plan facility – A provider or facility that we have not arranged with to coordinate or provide covered services to members of VIVA MEDICARE PLUS SELECT. Non-plan providers are providers that are not employed, owned, or operated by VIVA MEDICARE PLUS SELECT and are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by VIVA MEDICARE PLUS SELECT or Original Medicare.

Organization determination - VIVA MEDICARE PLUS SELECT has made an organization determination when we, or one of our providers, makes a decision about Medicare Advantage services or payment.

Original Medicare – Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Personal Care Physician (PCP) – A health care professional who is trained to give you basic care. Your PCP will generally provide and coordinate most covered services while you are a Plan member. Section 2 tells more about PCPs.

Plan provider – **"Provider"** is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**Plan providers**" when they have an agreement with VIVA MEDICARE PLUS SELECT to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of VIVA MEDICARE PLUS SELECT. VIVA HEALTH pays Plan providers based on the agreements it has with the providers.

Prior authorization – Approval in advance to get services. Some in-network services are covered only if your doctor or other Plan provider gets "prior authorization" from VIVA HEALTH's Medical Management Department. Covered services that need prior authorization are marked in the Benefits Chart.

Provider system – A grouping of Plan providers generally based on the hospital with which they are affiliated. You will receive most of your health care from Plan physicians and Plan hospital(s) within your selected provider system. If a covered service is not available within your selected provider system, VIVA HEALTH will identify another Plan provider who can perform the service.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in Alabama and Section 9 for information about making complaints to the QIO.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a Plan provider. See Section 6 for more information.

Service area – Section 2 tells about VIVA MEDICARE PLUS SELECT's service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

VIVA MEDICARE *PLUS SELECT*
MEMBER OF THE UAB HEALTH SYSTEM

A Medicare Advantage Managed Care plan with a Medicare contract brought to you by VIVA HEALTH®. Open to all Medicare eligible residents in our service area who are entitled to Medicare Part A and enrolled in Medicare Part B. Limitations and copayments apply. Enrolled members must use VIVA MEDICARE Plus network providers.

1400 21st Place South
Birmingham, AL 35205
Office Hours: 8 a.m.-5 p.m.
www.vivahealth.com

EXHIBIT B

VIVA MEDICARE *PLUS*
MEMBER OF THE UAB HEALTH SYSTEM

Dear PEEHIP Retiree,

Have your premiums increased with your current plan? Are you having second thoughts about your healthcare coverage? Then VIVA MEDICARE ***Plus*** may be the plan for you.

If you are a Public Education Retiree on Medicare and eligible for PEEHIP benefits, we have a special program for you. If you want more benefits than traditional Medicare offers, **VIVA PEEHIP** with **VIVA MEDICARE *Plus*** is an excellent choice. Best of all, **VIVA MEDICARE *Plus*** has no monthly plan premium (you continue to pay your Part B premium to Medicare). **VIVA MEDICARE *Plus*** is offered under a contract with the federal government. We offer the following benefits:

- **No Yearly Medical Deductibles**
- **$0 Physician or Specialty Copays**
- **$0 Hospital admission or One Day Surgery Copays**
- **$0 Ambulance or Emergency Room visit Copays**
- **A Comprehensive Dental Plan through CompBenefits**
- **Prescription Drug Benefit ($12 generics, $25 preferred brands, $45 non-preferred brands up to $3000 /year)***

Plus, added benefits such as:
$20 Towards YMCA Monthly Membership
$200 Allowance for Eye Glasses or Contact Lenses
20 free rides (10 round trips) a year for medical care

The open enrollment for this program ends August 30, 2006! Call **VIVA MEDICARE *Plus*** now to receive more information about the PEEHIP option and how to enroll: **(205) 933-8482** in Birmingham or **(888) 830-8482**. For TTY services, call the Alabama Relay Service at (800) 548-2546. We welcome any questions you may have and we look forward to serving you.

*This applies to **VIVA PEEHIP** with **VIVA MEDICARE *Plus***. VIVA MEDICARE *Plus* also offers a plan with Medicare Part D prescription drugs. Call now for more details.

1400 21st Place South, Birmingham, Alabama 35205
Phone (205) 918-2067 • 1-800-633-1542
For TTY Services: (205) 930-0264 • 1-877-853-1950
Our office hours are Monday through Friday from 8:00 am to 5:00 pm